

# WORKERS' COMPENSATION LAW

## SECTION NEWSLETTER



Summer 2003 • [www.gabar.org](http://www.gabar.org)

PUBLISHED BY THE WORKERS' COMPENSATION LAW SECTION

H. Emily George, Editor

### CHAIRMAN'S CORNER

BY THOMAS W. HERMAN

As of the Section's Luncheon on Friday, June 13, my tenure as chair will come to an end. It is hard to believe my time as Chair is complete. It has been a great year working with the members of, what I believe is, the best section of the State Bar of Georgia.

This year's Distinguished Service Award is being presented, posthumously, to E. Lamar Gammage, Jr. Taking into account the high standards exemplified by past recipients, the Executive Committee determined that Lamar was the only deserving individual of this year's award. Miles and a number of speakers will be at the luncheon to honor Lamar and his contribution to the practice of workers' compensation.

The section will continue its recognition and support of Kids' Chance at the meeting. Once again, Justice Benhem has agreed to present this year's Kids' Chance Scholarship. Many thanks go out to Emily George for getting Prescription RX to agree to sponsor both our luncheon and cocktail reception. Doug

see **Corner** page 18

## Effective Advocacy at Appellate vs. Trial Level

BY HONORABLE JUDGE VIOLA S. DREW

**H**aving served as a hearing judge for 10 years, and now as an Appellate Division judge for a year, I find that there are certain techniques of effective advocacy at the trial level that do not always transfer well into effective advocacy at the appellate level.

### Thoroughness vs. Brevity

#### *Trial Level*

When presenting a case before an administrative law judge, it is very important to be as thorough as possible. Good trial advocates should pursue all possible avenues of recovery and explore and present every possible rea-

sonable position on behalf of their clients.

#### *Appellate Level*

Brevity is the key word at the appellate level. The lawyers should have argued all their contentions to the administrative law judge, and the judge has considered all those contentions and made his or her decision. At the Appellate Division level, the lawyers have to be as brief as possible. Each side is permitted only five minutes of oral argument. Don't waste time making arguments and asserting positions upon which you are unlikely to

see **Advocacy** page 10

### INSIDE THE ISSUE

- Message from the Chairman-Elect . . . . . 2
- History of the Workers' Compensation System Keepsake Book . . . 3
- Workers' Comp Settlements with Medicare Set-Aside Arrangements . . . . 4
- Settling the Catastrophic Workers' Compensation Claim . . . . . 12
- Case Law Update . . . . . 14
- O.C.G.A. § 34-9-200(c): Be Careful What You Wish For . . . . . 19
- Kids' Chance Chat Room . . . . . 21
- Families of Freedom Scholarship Fund . . . . . 22

# Message from the Chair-Elect

BY DOUGLAS A. BENNETT

I am honored to have the opportunity to serve as the Chairperson of the Worker's Compensation Law Section of the State Bar of Georgia for the 2003-2004 Bar year.

At the same time, I recognize the big shoes I have to fill. Thomas Herman did an excellent job last year, and I want to personally thank him on behalf of the Section for his dedication and hard work. It has been a pleasure to serve with Thomas on the Executive Committee these past several years.

This is an exciting time to be a member of the Workers' Compensation Law Section. We anticipate publishing a book later this year that will honor our past, while we strive to make improvements in the futures. The history of the workers' compensation system in Georgia should be ready for publication in the Fall. We are certain that everyone will want to purchase a copy of this book. All profits will be donated to Kids' Chance. I want to thank Mark Gannon, who conceived this project and has spent countless hours assuring its completion.

E. Lamar Gammage Jr. is the recipient of this year's Distinguished Service Award, which will be given to his family at the State Bar's Annual Meeting in Amelia Island, Florida on Friday, June 13, during the Section's luncheon. Lamar was truly a giant in workers' compensation practice and we look forward to honoring his accomplishments and contributions to workers' compensation law in Georgia. It has been a memorable event in

the past, and I am certain this year's event will prove memorable as well. There is not a person practicing in the area of workers' compensation law in this state who was not affected in some way by the life and practice of Lamar Gammage.

Finally, in addition to the luncheon, there will be a cocktail reception at 5:30 p.m. on June 13. Lisa Wade has again planned an excellent program, and as usual has assured that we will have the best food and drink available. I look forward to seeing everyone at the State Bar's Annual Meeting.

I also look forward to another excellent program at the Annual ICLE Workers' Compensation Law Institute, which will be held October 2 - 4 on St. Simons Island. We are currently working on the program, which I am sure will be up to the high standards of past programs.

Emily George is responsible for publishing this newsletter. She has done an excellent job and I thank her for producing such a high quality product.

Finally, I urge you to become more involved with the Section. You will be better for it.

If you have any ideas or suggestions, please contact me or one of the Executive Committee members: Bob Wharton, Emily George, Tim Hanofee, Shari Miltiades and past Chair Thomas Herman.

I look forward to serving as your Chairperson this year. ♦

## 2003 Events Calendar

**June 13**

Section Luncheon - Amelia Island, Florida  
*Sponsored by Workers' Comp Rx*

**June 13**

Cocktail Reception - Amelia Island, Florida  
*Sponsored by Workers' Comp Rx*

**July TBA**

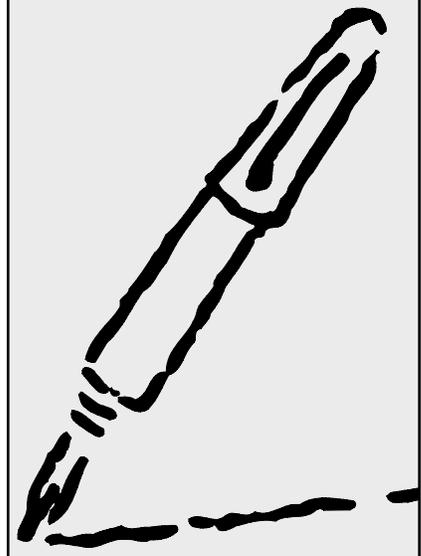
Kids' Chance Golf Tournament - Atlanta

**October 2 - 4**

ICLE Workers' Compensation Law Institute - St. Simons Island

**October 25**

Kids' Chance Fun Run - Lullwater Park, Atlanta



# History of the Workers' Compensation System - Pioneers and Practitioners

## A Keepsake Book for Any Workers' Compensation Practitioner

BY MARK S. GANNON

Almost one year ago, the Workers' Compensation Law Section entered into a written contract with Bookhouse Group, Inc. for the publication of a book chronicling the history of the workers' compensation system in Georgia from its inception through the end of the 20th Century. The book will be entitled *A Just and Noble Legacy: Compiling the History of the Workers' Compensation System in Georgia*.

I have spent my entire legal career practicing law in the workers' compensation arena. I was first attracted to this practice area because of the social purpose that our system fulfills in the orderly operation of our free economy. Each case has meaning and significance beyond its own confines and every lawyer who practices workers' compensation law has an obligation, beyond representing the best interest of his or her client, to ensure that the system operates in a manner that serves society's best interests.

Because this area of the law is so specialized, the attorneys who practice workers' compensation see each other in cases on a recurring basis. Often, this unique aspect of our area of practice results in lawyers developing meaningful and productive working relationships.

It is in the context of these relationships that we can enrich and enhance our substantive knowledge of the law and our practical

understanding of how the law should be applied to real life situations.

Under the best of circumstances we should all want to provide a legitimately injured worker with immediate and adequate compensation and medical treatment and the employee should be genuinely motivated to recover and return to work.

Employers need be mindful of the benefits afforded to business by virtue of the exclusive remedy and the ability to accurately project the cost of work-related injuries in forecasting overhead. We lawyers need to be as passionate about finding ways to work together as we are in advocating against those aspects of the system that do not inure to the benefit of our respective clients.

Nothing symbolizes more the commonality we share as practitioners than Kids' Chance, Inc. This marvelous educational scholarship fund is the brainchild of our past Section Chair, Bob Clyatt. I was in attendance at the Annual State Bar Workers' Compensation Breakfast in June of 1988 when Bob first proposed this inspirational idea to provide educational scholarships to the children of workers who have been seriously, catastrophically, or fatally injured in work-related accidents.

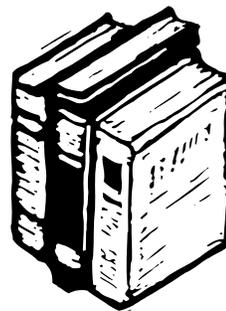
Since that time almost \$2,000,000

has been raised in Georgia, almost 300 scholarships have been awarded, and similar Kids' Chance programs have been organized in 21 additional states. Volunteers from 23 other states have asked for start-up kits.

Kids' Chance represents a cause that transcends our ideological differences. Most of the money raised by Kids' Chance comes from events and activities organized by the members of our Section.

During my tenure as Chairman, I proposed to the Executive Committee the idea of publishing this book. My goal is to chronicle a history of the workers' compensation system in Georgia that will serve as a valuable reference to workers' compensation practitioners and to preserve the legacy of the past for future generations of lawyers who will practice in this area of law.

The book will also raise money for Kids' Chance because the organization will receive all profits from the sale of the book. No other section of the State Bar has undertaken such an ambitious project, but then we have Kids' Chance to serve as an example of how an inspirational idea can become an unbelievable reality.



see **Book** on page 11

# Workers' Compensation Settlements with Medicare Set-Aside Arrangements

## Problem Solving the Issues

BY BEVERLY MANLEY

Medicare's inception as a secondary payer has its basis in § 1862 (b) of the Social Security Act [42 USC §§1395]. In 1980, in response to rising medical costs, § 953 of the Omnibus Budget Reconciliation Act was amended to significantly broaden the scope of the Medicare Secondary Payer Act (MSPA). The MSPA has received little attention until recently, due in part to the passage of the "Medicare Integrity Program" of 1996. The MSPA requires that payment of medical expenses be withheld "to the extent that ...payment has been made or can reasonably be expected to be made promptly under a work[ers'] compensation law or plan ... or under an automobile or general liability insurance policy or plan or under no fault insurance." 42 U.S.C. § 1395y(b)(2)(A)(ii).

On July 23, 2001, the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, issued a memo that further clarifies CMS policy regarding Medicare and Workers' Compensation settlements. (See July 23, 2001 memo published by Deputy Director Patel, Center for Medicare Management.)

A series of regulations found at 42 C.F.R. § 411.20 – 411.52 give effect to the provisions of the MSPA. Tracking the language of the MSPA itself, federal regulations at 42 C.F.R. § 411.26(a) state that Medicare is "subrogated to any worker, provider, supplier, physi-

cian, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer." Additionally, 42 C.F.R. § 411.24(g) states that Medicare "has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, private insurer, State agency, or private insurer that has received a third party payment." See *Colonial Penn Ins. Co. v. Heckler*, 721 F.2d 432 (3rd Cir. 1983) and *Abrams v. Heckler*, 582 F. Supp 1155 (S.D. New York 1984) for case law decisions that recognize the congressional intent to establish Medicare as a residual rather than primary payer, and recognized that any state law, which would interfere with this intent, would be superseded.

The Medicare Secondary Payer (MSPA) claim arises in the following contexts:

1. When providers are mistaken about who is the primary payer and bills Medicare in compensable workers' compensation claims. The "overpayments" subsequently become an MSPA claim in any WC settlement.

2. A WC claim is contested and the employee is without any health insurance benefits during the period of delay. § 3407.6(B) of the Medicare Fiscal Intermediary Manual (MIM) provides for conditional Medicare payments to avoid imposing a hardship pending a decision on compensability.

3. When a WC payer pays an amount for Medicare-covered services that is less than the provider's charges and less than the gross amount payable by Medicare, and the provider does not accept and is not required to accept the payment as payment in full under WC law.

### Threshold for Medicare Secondary Payer Statute (MSPA)

Not all WC settlements must be submitted to the CMS Regional Office for review. If the worker is not eligible for Medicare, CMS is not interested, unless the worker has a reasonable expectation of qualifying for Medicare within 30 months and the future medical expenses and indemnity being offered in the settlement (less expenses) exceed \$250,000.

What are the situations in which there may be a "reasonable expectation of Medicare enrollment within 30 months"? A "MSP-WC Frequently Asked Questions" memo published on April 22, 2003 by Director Thomas Grissom, Center for Medicare Management, provides clarification. These situations include but are not limited to:

1. Worker is receiving Social Security Disability (SSDI) benefits at time of settlement.

2. Worker has applied for SSDI or has applied and been denied but anticipates appealing the decision.

3. Worker is in the process of

appealing and/or re-filing for SSDI benefits.

4. Worker is 62.5 or greater at time of settlement.

5. Worker has End Stage Renal (ESRD) disease but does not qualify for Medicare based on ESRD.

However, if the injured worker is already eligible for Medicare, Medicare's interests must always be considered, regardless of the amount of settlement. Where Medicare's interests must be considered, CMS regional offices can issue written opinions on which the case parties can rely regarding whether Medicare's interests are being adequately considered in a particular settlement. Provided Medicare's interests are being adequately considered, the carrier is given a full release and, once the funds in the Medicare Set Aside arrangement are exhausted on injury related medical expenses, the worker is eligible for Medicare coverage for future medical expenses.

CMS has mandated that all cases involving a Medicare beneficiary must have a set aside arrangement. This means that set-asides for future medical care could be as low as five to twenty thousand dollars. Medical annuities may be used to fund a Medicare set aside arrangement. However, it should be noted that if the arrangement is funded with the annuity, the amount of the structured periodic payment may be insufficient, in a given year, to cover unanticipated expenses. In an April 22, 2003 Grissom memo this issue is addressed. The Memo makes provision for Medicare's payment for the unpaid medical care once the funds apportioned to that period have been exhausted and an accounting has been made to Medicare and approval has been

given of the set aside paid out claims.

### Compromised vs Commutation Claim

Medicare's regulations (42 CFR 411.46) and the Medicare Fiscal Intermediary Manual, Part 3 (MIM) §§ 3407.7&3407.8 and Medicare Carrier's Manual (MCM) §§ 2370.7 & 2370.8) make a distinction between lump sum settlements that are commutations of future benefits and those that are due to a compromise between the workers' compensation carrier and the injured worker.

The CMS defines a commutation as a "settlement in which the beneficiary accepts a lump sum payment as compensation for all future medical expenses and disability benefits related to the work injury or disease." There is clearly intent to compensate for future medical expenses. A commutation settlement must allocate an amount toward medical expenses that "reasonably considers" Medicare interests. When a claim is commuted and the settlement is intended to compensate the injured worker for all future medical expenses in connection with the work injury, a set-aside arrangement is mandated.

Compromise claims are those in which liability is contested and often, although not necessarily, involve claims that have been controverted. Therefore, compromised settlements provide less in total compensation than the worker would have received if the claim had not been compromised and are intended to compensate the worker for current or past medical expenses. However, a settlement may be considered a commutation regardless of whether the parties admit or deny liability. Set aside arrangements are not used in WC compromised claims. Designation of the

claim as a compromised or commutation settlement depends solely on whether the settlement involves future medical expenses.

A single WC lump-sum settlement agreement can possess both WC compromise and commutation aspects. That is, some single lump-sum settlement agreements can designate part of a settlement for an injured worker's future medical expenses and simultaneously designate another part of the settlement for all of the injured worker's medical expenses up to the date of settlement. This means that a commutation case may possess a compromise aspect to it when a settlement agreement also stipulates to pay for all medical expenses up to the date of settlement. Conversely, a compromise case may possess a commutation aspect to it when a settlement agreement also stipulates to pay for future medical expenses. Therefore, it is possible for a WC lump-sum settlement agreement to be both a WC compromise case and a WC commutation case. Medicare regulations at 42 CFR 411.46 state that:

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

In addition, the Medicare manuals (§3407.8 of the MIM, §2370.8 of the MCM) state:

"When a beneficiary accepts a lump-sum payment that represents a commutation of

all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump-sum is made, until the beneficiary presents medical bills related to the injury equal to the total amount of the lump-sum settlement allocated to medical treatment.”

No liability stipulations are not exempt from the MSPA Act. In congruence with 42 C.F.R. 411.46(b)(1), a lump sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes, even if it is stipulated that there is no liability.

**Enforcement Provisions**

Even in compromise settlements, failure to designate an amount allocated toward medical expenses as being in payment of past medical expenses incurred, will result in CMS withholding payment of future medical expenses up to the amount of such allocation. See 42 C.F.R. § 411.46(d)(2). If no allocation is made, 42 C.F.R § 411.47(a) provides a formula by which CMS will decide what portion will be attributed toward “future medicals,” and may choose to treat the entire lump sum amount as a payment toward future medicals.

If an injured worker has been a SSDI beneficiary for some time before retaining an attorney for representation and has an open claim for workers' compensation, there is a likelihood that Medicare may have made conditional payments that the workers' compensation payer should have paid. CMS

has a direct right of action against the insurer, employer, or any entity required or responsible to pay for recovery of its conditional payments. See 42 C.F.R. §411.24(d). This direct action may include injured workers, attorneys, and providers who have received payment from the primary payer. See 42 C.F.R. § 411.24(e) & (g). When an injured worker, attorney, or medical provider receives a third party payment, they are under an obligation to reimburse Medicare within 60 days. 42 C.F.R. 411.24(h). Thus reimbursement must be made to Medicare within 60 days of the day the injured worker receives the settlement check following State Board approval of the agreement. There is a private cause of action (double add-on to the recoverable amount) against the employer/insurer that fails to reimburse Medicare. 42 U.S.C. § 1395(y)(b)(3)(A).

In the event that reimbursement is not made to Medicare as required by 42 USC 1395y(b)(2)(B)(I), action may be brought against any entity responsible for payment (and may collect double damages from insurance companies), or any entity that has received a third-party settlement. Under 42 CFR 411.24(g), this includes attorneys whose fees are paid from settlement proceeds. Note that CMS may also intervene (not initiate) in any action related to the events that gave rise to the need for the medical service. See *In Re Dow Corning* 250 B. R. 298, 338.

**Reasonable Consideration of Medicare's Interests**

Although 42 CFR 411.46 requires that all WC settlements must adequately consider Medicare's interests, the regulation does not mandate what type of arrangement must be used to set aside funds for Medicare. If an arrangement is self-

administered, then the injured worker/beneficiary must adhere to the same rules/requirements as any other administrator of a set-aside arrangement.

In accord with 20 CFR §404.408(d), the funds allocated to a set aside arrangement must be consonant with the applicable law or plan 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. The agreement creating the set-aside arrangement must also contain terms that address the provider's agreement to abide by the WC fee schedule reimbursement level. (e.g., providers will be reimbursed out of the set aside arrangement at the WC rate for medical services rather than the physicians regular full rate or the Medicare rate for covered services).

The Patel memo outlines two methods for medical providers to obtain payment for WC covered services when funds are held in a set-aside arrangement. The memo clarifies that the payment method depends on two factors: 1.) How the set-aside arrangement is constructed and 2.) Whether the arrangement was constructed by contemplating full actual charge estimates or WC medical fee schedule.

The memo further states that there must be specific provisions in the

settlement agreement that clarify the set aside arrangement will reimburse medical providers in accordance with the WC medical fee schedule. Once the CMS regional office has reviewed and approved the sufficiency of the arrangement based on the WC medical fee schedule, then medical providers will be paid based on what would normally be payable under the WC plan (i.e., under the WC medical fee schedule). The settlement agreement should include five separate categories in order to safeguard the workers' Medicare benefits and Social Security Disability payments: 1) past medicals (a lien only can be asserted against that portion allocated to past medicals); 2) future medicals (not including skilled care); 3) future medicals (intended for skilled care); 4) indemnity (lifetime lost wages); and 5) attorney's fees and costs.

After the set aside funds are depleted, there must be a complete accounting to the Medicare 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. Note that section 3416 "Effect of Lump Sum Compromise Payment" of the CMS Intermediary Manual directs the Medicare contractor to retain a copy of the lump-sum agreement and flag any new claims for the condition for which the beneficiary received the lump-sum payment in order to assure accuracy of the payment on claims.

**CMS Criteria to Determine if Allocation is Reasonable**

The Patel memo also outlines what must be submitted to the CMS

regional office in order to make a determination that a set-aside arrangement reasonably considers Medicare's interests.

This documentation includes 1) Date of Medicare entitlement; 2) Basis for Medicare entitlement; 3) Type and severity of injury or illness; 4) Beneficiary's age, rated age and life expectancy; 5) WC classification of beneficiary as permanently or partially disabled; 6) Prior medical expenses; 7) Amount of settlement and allocations to indemnity and future medical expenses with an explanation of the basis for the amounts of projected expenses for Medicare covered services and services not covered by Medicare (this could be a copy of letters from doctors/providers documenting the extent, duration, and necessity of continued care); 8) Whether commutation is for the worker's lifetime or some other period; 9) The beneficiary's living arrangements (e.g., at home, nursing home, etc.); and 10) Whether expected future medical expenses are appropriate in light of the worker's condition.

Other documents required by CMS to determine "reasonableness" may include a copy of the settlement agreement, rated age, and letters from providers establishing the future care needs and the provider's agreement to WC fee schedule reimbursement for the future medical care.

Additionally, CMS makes clear that the regional office will be looking for some detail as to an investment policy and return on the set aside funds. Also, CMS states that a set aside arrangement may be self-administered. Note that it is not considered reasonable to fund a set-aside arrangement with a set number of years of anticipated

medical expenses. However, the funds allocated to the set aside arrangement need not necessarily equal the worker's calculated medical expenses for life.

**Practice Tips**

There must be some reasonable and verifiable additional sources outside the settlement agreement that document the basis for arriving at the allocation amount. See *Barrett v. Massanari*, 2001 WL 1193716, 2001 U. S. Dist. LEXIS 16232. Reasonableness can be demonstrated by a treating provider report and prognosis documenting frequency and duration of future care, an independent medical exam, a functional capacity evaluation, and/or retrospective review of an injured worker's claims history.

But see the decision in *Norwest Bank and Kenneth Frick vs. K-Mart Corporation*, U. S. District Court, Northern District of Indiana, Case No. 3:94-CV-78RM, found at 1997 U. S. Dist LEXIS 3426, decided January 29, 1997, that excluded a life care plan with an analysis of future medical needs based upon a retrospective review of medical records as inadmissible under Federal Rules of Evidence 702. When future care recommendations from treating providers can be obtained, that is the most defensible and consistent approach with life care planning methodology to be followed in the calculation of the set aside allocation.

As an example of how the provider recommendations can impact the set-aside amount, the following case study illustrates this point. A cost projection completed by a Medicare health care consultant using a rated age of 54 and a retrospective review of the medical records and billing summary recommended a set-aside allocation of

\$101,396.00. Using the same medical records, same medical billing summary, and same rated age but obtaining treating provider recommendations, the recommendation for the set aside allocation was \$55,735.00. The cost savings came from the provider recommendations. In response to treating provider questionnaires, the psychologist recommended only two years of psychotherapy and the physical therapist recommended a gym membership and in home therapy exercises with no further treatment at the clinic. See below for details of comparison.

**Case Study of IW Jessie  
Chronological age 44  
Rated age 54 LE 27.22 years**

**Using Provider Questionnaires**

Office visits <i>(Pain mgmt; Prescription mgmt)</i>	\$14,361
Therapeutic intervention <i>(Psy'therapy 2 yrs; Annual PT eval)</i>	\$2,286
Diagnostic & Lab work	\$14,318
TENS unit & supplies	\$14,127
Orthpedic needs	\$6,533
One-time trial spinal cord stimulator	\$4,110
<b>TOTAL</b>	<b>55,735</b>

**Retrospective Review Using  
Medical Billing Summary**

Office visits <i>(neurological &amp; ortho)</i>	\$2,156
Pain Mgmt <i>(monthly)</i>	\$25,872
Prescription Mgmt	\$8,400
Psychotherapy <i>(monthly)</i>	\$37,968
Lab work	\$2,800
Diagnostic x-rays & MRI	\$7,000
TENS unit	\$400
TENS supplies	\$16,800
<b>TOTAL</b>	<b>\$101,396</b>

The issue of how to deal with settling a claim when a rated age is used to determine the set-aside

allocation has arisen. Rated age is a concept borrowed from the life insurance industry. Life underwriters routinely assign a "risk" classification that is based on an applicant's medical history, marital status, occupation, and personal habits such as tobacco and alcohol use. The premium is based on the applicant's life expectancy taking into consideration these health risk factors. The actuarial premise is that certain health conditions are known to shorten life. The applicant's rated age is based upon a medical underwriter or an in-house actuary's review of the medical records and the resultant rating of the applicant's expected life expectancy.

The use of the concept of rated age in WC settlements can result in a lower Medicare set-aside amount. Since the use of a rated age advances the injured worker's chronological age the most and thereby reduces the set-aside, it is an attractive option. CMS recognizes this and makes allowances for the use of a rated age in the Patel memo. A cursory exam of the set aside allocation based on a rated age may not raise any concerns.

However, a closer exam of the issues is warranted. A calculation based on the injured worker's chronological age can be easily made from the set aside allocation based on the rated age when it is given in the MSA cost projection. The risk of malpractice is increased when the settlement is based on the use of an "undisclosed" rated age. Careful consideration must be given to the difference between the non Medicare covered future medical expenses based on the injured worker's life expectancy using his rated age and the allocation for future care that is based on the worker's chronological age. To discount the difference between the two amounts could result in the

costs of non-Medicare covered future medical care being undervalued. Because it advances the injured worker's age, the use of rated age factors out indemnity benefits as well as the non-Medicare covered medical expenses.

Consideration also needs to be given to the offset provisions based on the life expectancy using the rated age versus the chronological age. It should be noted that the age ratings are given by insurance companies that are, in turn, also rated by A.M Best. A careful analysis of the total medical and indemnity costs factoring in the offset provisions is the only way to ensure an equitable settlement.

There are instances when the worker is not currently entitled to Medicare and does not require CMS approval but has been accepted for SSDI or is approaching Social Security Retirement and Medicare entitlement appears reasonable within 30 months. How should these types of settlements be handled? The advantages to identifying a Medicare set aside arrangement are that only the amount apportioned for future injury related Medicare allowable care must be spent on same before Medicare benefits will be available for injury related Medicare allowable expenses in the future. The disadvantages are that the allocation can only be spent on Medicare allowable injury related care. Payments to the providers must be WC fee scheduled. Finally payments cannot be made from these funds until the worker's enrollment date in Medicare is reached. Conversely, if a Medicare set aside allocation is not made, the advantages are that the worker can begin spending the medical apportionment on all medical related expenses immediately. The medical payments do not have to be

reduced to the WC fee schedule. But the entire amount of the medical apportionment must be spent before Medicare benefits will be available for injury related Medicare covered expenses in the future. Note that the entire future medical apportionment is usually significantly more than the amount apportioned for future injury related Medicare allowable expenses only. In either option, the worker will need to save medical receipts and submit proof to CMS of spending the amount as outlined in the settlement agreement before future Medicare benefits for injury related can be received.

**Conclusion**

The objective of the MSPA is to ensure that workers' compensation primary payers do not shift the responsibility for payment of medical services to Medicare. If an injured worker is under 62 years and six months of age and does not qualify for Social Security Disability Insurance, then there is no exposure. Consideration of the MSPA Act is not necessary when you are drafting settlement agreements.

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 WC. Because an arrangement's purpose is to pay for all services related to the worker's on the job injury or disease, Medicare will not make any payments (as a primary, secondary or tertiary payer) 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 injured worker's attorney to properly inform his client, prior to the

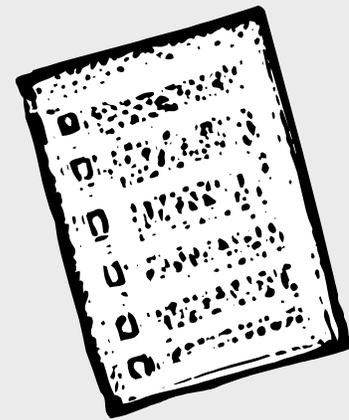
settlement of his claim, of the possible consequences the settlement can have on his Medicare entitlement for future medical care.

When proposed medical care for the injured worker is very costly, the only way to guarantee eligibility coverage by Medicare once the set aside funds are depleted is to obtain CMS pre-approval of the proposed settlement allocation. Future entitlement to Medicare is an integral element in these settlement evaluations.

Recommendations as to future medical care from the treating physicians are needed with negotiated costs calculated. A cost projection of future medical needs is a necessary part of allocating appropriate funds for recommended medical services. Looking at the claims history and cost is not sufficient. Medicare set aside trusts based on the life care plans and/or cost projections are appropriate for these high dollar settlements. However, when the injured worker is at or near MMI and the proposed medical care is palliative in nature, self-administered or custodial set-aside arrangements are more appropriate. ♦

**Resource List**

1. Director Thomas Grissom  
Memo published July 23, 2001: See [www.cms.hhs.gov/medicare/cob/pdf/wc\\_faqs.pdf](http://www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf)
2. For additional information on the Medicare Secondary Payer provisions, see [www.georgiamedicare.com](http://www.georgiamedicare.com); click on Attorney Information.
3. Region IV CMS staff that process Medicare Set Aside arrangements:  
Juanita Dixon 404-562-7313  
Geraldine Taylor 404-562-7311



**Know someone who is interested in joining the Workers' Compensation Law Section?**

Tell them to send their name, address and Bar number, along with a \$20 check made payable to the State Bar of Georgia to:

State Bar of Georgia  
Membership Dept.  
104 Marietta Street, NW  
Suite 100  
Atlanta, GA 30303

If you received this newsletter then you're a member of the section till June 30, 2003. If you haven't renewed your membership for the upcoming Bar year, do so today!

**Effective Advocacy**

Continued from page 1

prevail. Focus primarily on the errors you feel were made at the trial level that would justify a reversal of the case.

**Credibility**

*Trial Level*

Determining the credibility of the witnesses is a critical component of deciding the case for the trial judge. Accordingly, making credibility issues a focal point of the case and spending a lot of time on impeachment of witnesses makes sense for the advocate at the trial level.

*Appellate Level*

The Appellate Division consistently holds that the administrative law judge is in the best position to determine the credibility of the witnesses and weigh the evidence. Since the administrative law judge was at the hearing and had the opportunity to observe the witnesses, it is unlikely that the Appellate Division is going to disturb credibility determinations by the administrative law judge.

**Flexibility**

*Trial Level*

When preparing for a hearing, a lawyer should have carefully crafted the most advantageous order to present the evidence in his or her case. The lawyer should then attempt to stick to that order during the presentation of the case to the trial judge.

*Appellate Level*

When appearing before the Appellate Division, a lawyer should plan the argument, but be flexible enough to be able to easily deviate from that planned argument in order to respond to questions that may be asked by the appellate division judges. The judges' questions will reflect the

issues they feel are important in deciding the case, and responding to the judges' questions may be more important in getting the desired outcome than finishing the argument exactly as planned.

**Briefs**

*Trial Level*

The brief that is filed with the trial judge should cover all the issues in the case. At the trial level, you want your brief to discuss every issue that was presented at the hearing.

*Appellate Level*

You should be much more selective about the issues raised in your brief before the Appellate Division. There is no need to file a brief that is exactly the same as the brief you filed for the trial judge. The appellate brief should highlight only the significant issues that you feel constitute reversible error.

Organize your brief into major subject areas and cite to the relevant pages in the transcript and exhibits. Respond to the other party's argument and be specific about the relief requested. Even more attention should be given to the briefs in cases that are decided as "submits", rather than after oral argument.

Contrary to popular belief, submitted cases do receive the same level of review as cases that are argued before the Appellate Division. However, the briefs in submitted cases need to be carefully written to emphasize the points you want to make since the Appellate Division judges do not have the benefit of having these points presented in oral argument.

**Overly-Zealous Litigation Techniques**

*Trial Level vs. Appellate Level*

While confrontational litigation

techniques may be of some marginal benefit when attacking an adverse witness as part of a zealous and "skillful" cross-examination, such techniques have no place in the appellate process. If you were unsuccessful in impeaching the witness at the hearing, it is too late to try to accomplish this at the appellate division level.

The better practice is to raise and discuss the relevant legal points without resorting to attacks on the opposing parties, their counsel, the physicians in the case and the trial judge. An eloquent oral argument that points out the shortcomings of the opposing party's case and the errors allegedly made by the trial judge is always welcome before the Appellate Division. However, overly zealous confrontational conduct before the Board, whether by brief or during oral argument, will only detract from your legal position and make it more difficult to focus on any meritorious position you may have.

**Preparation**

I have tried to point out some brief examples of differences in effective advocacy at the appellate and trial levels. However, the one technique that is equally effective at the trial level and the appellate level is preparation.

Being intimately familiar with the facts and law of your case and being able to impart that knowledge to the judge is probably the most effective technique, whether presenting your case at the trial or appellate level. The most prepared attorney will be the most effective advocate at any level of the litigation process. ♦

**Keepsake Book**

Continued from page 3

The book will begin with a history of the creation of the workers' compensation system in Georgia by statute. There will be a historical overview of how the system evolved from its Western European origin to its creation by statute and evolution in Georgia. The book will chronicle how a small group of lawyers shaped the application of the law to the administration of the system and how the practice of workers' compensation grew as major changes reshaped the legal landscape.

The book will document the landmark cases that heavily influenced the Georgia workers' compensation system and the attorneys who handled these cases will take the reader behind the scenes with their unique perspectives on the outcome of these precedent-setting cases.

The book will be replete with anecdotal accounts and quotes from lawyers who rode the workers' compensation circuit throughout the state.

A significant effort is being made to endow the book with geographic balance. The book will also chronicle the relationship between the attorneys representing each side and how the animosity prevalent in the early days began to fade as members of the Bar built positive working relationships through recurring encounters in cases.

The role of politics is also addressed as the book recounts how the political interests of labor, management, and insurance have jockeyed for influence to shape the

nature and breadth of our workers' compensation laws.

Appropriately, an entire chapter will be devoted to Kids' Chance and how this wonderful cause has served to bridge the gap between adversaries as we have joined forces to make Kids' Chance the success it is today. Kids' Chance students will be profiled and their successes chronicled.

Finally, the book considers the future of the workers' compensation system in Georgia and the challenges that lie ahead. It concludes with the notion that the attorneys who practice workers' compensation must work toward a consensus as to what is in the best interests of Georgia in the fair and effective development of our system.

The cost of this substantial undertaking is in excess of \$55,000. The contract we signed with Bookhouse Group Inc., provides a five per cent rebate of the initial contracted price for every direct referral of new business to Bookhouse resulting from the publication of our book.

Our publisher believes that the legal community will be a fruitful source of future business and our book will be a very useful marketing tool. Any rebate will reduce the cost and increase the profit payable to Kids' Chance.

In an effort to decrease the cost to the Section for this substantial undertaking, thereby enhancing the profits which will be paid to Kids' Chance, the Executive Committee is offering sponsorships for the book in the name of individuals, law firms, businesses, and other organizations. The cost of the different levels of sponsorships are as follows:

- Gold - \$5,000
- Silver - \$2,500
- Bronze - \$1,000
- Sponsor - \$100

All sponsors will be appropriately recognized in the body of the book. The projected comple-

tion date for the book depends upon our ability to raise funds to complete the seven stages of publication. Thus far, the Section has paid out of Section funds more than \$22,000 toward the total contract price. We will need to raise the rest of the money through sponsorships in order to bring this project to a successful conclusion.

Anyone interested in becoming a sponsor can contact me or Thomas Herman, Section Chair. We are in the process of determining whether we can establish a method of paying for these sponsorships on a tax deductible basis. Please help us make this idea become a reality. ♦

The book will document the landmark cases that heavily influenced the Georgia workers' compensation system and the attorneys who handled these cases will take the reader behind the scenes with their unique perspectives on the outcome of these precedent-setting cases.

# Settling the Catastrophic Workers' Compensation Claim

## Medicare and the Set-Aside Trust

BY MICHAEL R. CASPER

The Set-Aside Trust is now being used in settlement of catastrophic workers' compensation cases to satisfy Medicare concerns relating to responsibility for future medical expenses arising out of the employee's job injury. Employees in such cases no longer have the luxury of setting their claims for the maximum value including future medical expenses, pocketing the entire settlement, and then applying for SSDI disability which includes Medicare in order to pay for future medical needs arising out of the worker's compensation injury.

In early 2001, rumors began circulating that Medicare was considering filing claims for reimbursement against an insurance carrier to determine whether medical expenses of former workers whose workers' compensation cases had settled were later paid under SSDI disability Medicare. The basis for the claims by Medicare was 42 CFR 411.46 which requires certain workers' compensation settlements to adequately consider Medicare's interests. The prospect of Medicare "reaching back" and recovering medical expenses paid by Medicare from the worker's compensation carrier long after claims had been settled had a distinct "chilling" effect on the employers' and insurance carriers' desire to settle cases which involved potentially large future medical expenses. Settlement of catastrophic workers' compensation cases literally ground to a halt. Fortunately, the Set-Aside Trust

has been utilized to provide for future medical needs under Medicare and guidelines were issued by Medicare to clarify the settlement procedure. On July 23, 2001, the U.S. Department of Health and Human Services issued a memorandum regarding workers' compensation settlements in order to ensure that Medicare's interests were properly considered in settlement of workers' compensation catastrophic cases.<sup>i</sup> All settlements involving commutation aspects of future medical expenses require review and approval of the Regional Office (RO) in order to compromise any Medicare recovery claim.<sup>ii</sup> The memo explained that a Set-Aside Trust could be used in workers' compensation catastrophic settlement cases where an injured claimant either has already qualified for Medicare or may qualify for Medicare through SSDI to provide a reasonable amount for the present and future medical needs of the claimant. The use of the Medicare Set-Aside Trust enables Medicare to identify and analyze the appropriateness of the future medical care needs contained in the settlement and to issue a letter approving the Set-Aside amount for future medical expenses. After exhaustion of the proceeds of the Trust, Medicare would then pay for medical expenses under Medicare payment guidelines.

Critical to gaining approval by Medicare for the settlement Trust is the preparation of a future medical projection analysis by a consultant

to review the medical records and to project future medical needs of the claimant. Since in catastrophic cases the future medical care is usually a principal component of settlement, the claimant's attorney would have already secured future medical information from the principle treating physicians in addition to medical records. This can be done through the use of medical statements prepared by the claimant's attorney which requires the treating doctor to "fill-in-the-blanks." A cottage industry of medical analysis companies has emerged to provide a projection analysis information to Medicare. Without this critical information, it is unlikely that any settlement will be approved since the assignment of funds to the Medicare Set-Aside Trust is a key element in the approval by Medicare.

The workers' compensation settlement stipulation should also contain language regarding Medicare considerations. The agreement should recite the designated purpose of setting aside a portion of the settlement for the Set-Aside Trust under the direction of a custodian, who will need to be designated. Companies offering custodian services are now available to serve as the permanent custodians of the Set-Aside Trust.

The Trust should be "triggered" by the approval of the overall worker's compensation stipulation by the Board and the funding by the employer/insurer of the designated funds into the Trust. Some important considerations for the claimant's attorney to consider when

drafting the Trust:

- (1) Definitions of qualified medical expenses, supplemental medical services, and physicians must be set out which are compatible with Medicare definitions.
- (2) The duties of the custodian must be set out, including responsibilities for paying not only medical expenses for claimant, but preparation and filing of tax returns on the Trust and any tax due on income earned by the Trust. (The corpus of the Trust is commonly invested in an FDIC insured money market account). Also, annual reports of monies earned and paid out, along with copies of the return upon closing the Trust, and tax returns should be required from the custodian with copies to the claimant.
- (3) Qualified medical expenses to be paid out of the Trust must be defined by one of three possible standards:
  - (a) worker's compensation medical charge standard,
  - (b) Medicare charge standard, or
  - (c) Regular and customary medical charge standard (full charge).
- (4) Provision should be made for disbursement of the remaining corpus of the Trust to claimant's estate in the event of the death of the employee.
- (5) Provision should be made for disbursement of the remaining corpus of the Trust to claimant in the event of termination of Medicare eligibility of the employee.
- (6) Provision for dealing with disputes regarding the execution and performance of the Trust, such as arbitration and a situs for the arbitration. (It is likely that the parties will reside in different states).
- (7) Provisions for general liability bonding or insurance of the custodian to guarantee faithful performance of the Trust.
- (8) Consideration should be given to making the claimant a party to the Set-Aside Trust for standing by the claimant to enforce the agreement against either the custodian or insurer.
- (9) Provisions should be made

for successor custodian in the event the original custodian is no longer able to serve.

Great care should be exercised in the drafting of the Trust and Settlement documents since they will have significant impact on the claimant for his life expectancy. Claimant attorneys should not hesitate to associate and/or review with experienced counsel the procedures for settlement of these cases. Experienced attorneys should offer their assistance to claimant's counsel to educate our worker's compensation bar in these cases to minimize mistakes and omissions in the process.

The proposed Set-Aside Trust Agreement will be forwarded for Georgia cases to Ms. Juanita Dixon, at the Center for Medicare/Medicaid Services (CMS), 61 Forsyth Street, S.W. Suite 4T20, Atlanta, Georgia, 30303-8909. With the Trust should be an analysis from a healthcare consultant reviewing the claimant's projected medical needs for his lifetime, pertinent medical records and the proposed workers' compensation settlement stipulation. Allow at least three months for an opinion to issue regarding approval or disapproval of the Trust.<sup>iii</sup> The letter from CMS will also, if it approves the Trust, identify the Medicare contractor whose responsibility it will be to monitor the case and to whom the annual summaries of payments will be sent by the custodian of the Trust.<sup>iv</sup>

Currently, attorney's fees are not charged on medical set-asides or trusts, just on the non-medical portion of the settlement. Since the preparation of the Medicare Set-Aside Trust is a complicated and detailed procedure requiring considerable time and effort, it is the author's judgement that the attorney's fee issue in catastrophic cases should be re-evaluated by the Board of Workers' Compensation, and perhaps a contingency fee of ten to fifteen percent of the sum in the Trust

would be appropriate for attorney's fees in addition to the regular fee.

Workers' Compensation settlements in appropriate catastrophic cases are now viable again through the use of Set-Aside Trusts and the Medicare approval process. Although the time required to negotiate and settle the case has been lengthened due to Medicare involvement, at least the parties have the assurance that the claim is settled without risk of future liability or reimbursement responsibility by the employer/insurer. ♦

See Footnotes on Page 24.

Michael R. Casper is a Gainesville attorney in the firm of Michael R. Casper, P.C., which he founded in 1974. His practice is limited to trial practice-personal injury and wrongful death, and workers' compensation law.

Casper graduated from the University of Georgia in 1969 with Honors in English and lettered as a varsity diver on the U.G.A. swimming team. He received the Juris Doctorate degree from the University of Georgia School of Law in 1972.

Casper has served as Secretary-Treasurer and President of the Gainesville-Northeastern Bar Association, area vice-president of the G.T.L.A., and member of the American Trial Lawyers Association. He has served as adjunct Professor of Law at Gainesville College and Director of the Legal Assistant Program at Gainesville College and has also written and lectured on law related topics.

# Case Law Update

BY E. LEE SOUTHWELL, III

There is an apparent conflict in code section 34-9-104(a)(2). In general, that code section provides that if an employee is released to return to work with restrictions and is not working, that employee is not entitled to collect temporary total disability benefits for a period in excess of 52 consecutive weeks or 78 aggregate weeks. At the expiration of that period comma benefits are automatically converted to temporary partial disability benefits. One portion of that code section requires that the employer/insurer give the employee notice of the release to return to work with restrictions and give the employee notice that the conversion of benefits will occur after 52 consecutive weeks.

Board Rule 104 requires that notice be given on a Form WC-104 with the medical report from the authorized treating physician attached and that a Form WC-2 be filed at the time the conversion takes place.

Another portion of the code section provides that "in no event" shall temporary total disability benefits be paid while the employee is released to work with restrictions and not working for a period in excess of 78 aggregate weeks. The issue presented in *City of Atlanta v. Sumlin*, 258 Ga. App. 643 (2002) was whether "in no event" meant "in no event" even if the employer/insurer did not comply with the notice provisions of code section 34-9-104(a)(2) and Board Rule 104. In that case, the employee suffered a compensable injury and had a period of total disability. He was released to return to work with restrictions for the first time in

1998. At that time, the employer did not send the employee a Form WC-104 or a copy of the physician's report.

In 2000, after more than 78 weeks had elapsed from the original release to return to work with restrictions, the authorized treating physician reiterated the release to return to work with restrictions. Based on the 2000 release, the employer filed a Form WC-104 and Form WC-2 immediately converting the employee's benefits to temporary partial disability and served copies of these forms on the employee.

The employee requested a hearing, and the trial administrative law judge ruled that the employer improperly converted benefits. The administrative law judge ruled that the employer was not entitled to make an immediate conversion in 2000 when it did not give the notice required by code section 34-9-104(a)(2) at the time of the original release in 1998. The administrative law judge held that the notice provisions of the code sections were essential and that the 52-consecutive-weeks and 78-aggregate-weeks limitations did not begin to run until proper notice was given. The Appellate Division and the superior court affirmed. The court of appeals also affirmed. The court of appeals agreed that it was essential that the employee have notice of the release to return to work with restrictions and the consequences of that release before the employee's temporary total disability benefits were taken away. Therefore, "in no event" did not quite mean "in no event." It means "In no event," once the notice requirements of code section 34-9-104(a)(2) and Board Rule 104 have

been complied with. Thus, the automatic conversion may take place only after the requirements of due process have been met.

Board Rule 82 requires that any defense based on the running of a statute of limitations must be raised at or before the first hearing in a claim, or that defense is waived. The original version of this rule became effective in 1975. Prior to that time, there had been conflicting case law as to whether a statute of limitation defense was an affirmative defense or was a matter of subject matter jurisdiction. The case of *House v. Echota Cotton Mills*, 129 Ga. App. 350 (1973), had held that the statute of limitation defense could be raised at any time prior to the entry of the first award. Nevertheless, the Trial and Appellate Divisions had applied Board Rule 82 according to its literal terms in all-issues cases.

The rule was expanded to cover change-in-condition cases in *Baugh-Carroll v. Hospital Authority of Randolph County*, 248 Ga. App. 593 (2001). This principal was reaffirmed in *AT&T v. Barnes*, Ct. App. No. A03A0196, decided February 14, 2003. In that case, the issue on the merits was whether employer had properly suspended employee's income benefits. Employee requested a hearing to determine this issue. The hearing request was filed more than two years after the last payment of income benefits under code section 34-9-261 or 34-9-262 was actually made. Employer did not raise the affirmative defense of the running of the statute of limitation prior to the end of the hearing before the administrative law judge. The

statute of limitation defense was raised prior to issuance of the administrative law judge's award. The administrative law judge held that the defense was waived because it was not timely raised. The Appellate Division affirmed, and the superior court was deemed to have affirmed by operation of law. The court of appeals granted discretionary appeal and also affirmed. The court of appeals discussed the plethora of cases on the issue of whether the statute of limitation is an affirmative defense. The court of appeals pointed out that the overwhelming majority of cases held that it was.

The court of appeals once again reaffirmed the validity of Board Rule 82 and held that the affirmative defense of the running of the statute of limitation had to be raised at or before the first hearing, or it was waived. To the extent that *House v. Echota Cotton Mills*, supra, allowed the defense to be raised at any time after the hearing, that case was overruled by a 12-0 vote.

The case of *Harris County Sheriff's Office v. Negrete*, Ct. App. No. A02A1987, decided February 26, 2003, deals with the scope of employment of a law enforcement officer. In that case, Negrete was a deputy sheriff but was also authorized to perform part-time security work. He was allowed to use a county patrol car to travel to and from that part-time work. According to sheriff's department rules, when he began to travel to or from such part-time security work, even though he was ostensibly off duty, he was required to report to the dispatcher that his vehicle was in use. He was required to carry his badge, identification, and authorized weapon. He was required to respond to emergency calls, calls from other officers for backup, to render assistance to the

public when the need was obvious, and to be on the alert to observe suspicious activity. Both he and the sheriff testified that he was performing the same law enforcement functions while proceeding to and from his part-time job as he did when he was actually on duty. Negrete was injured in an automobile collision while traveling to his part-time job. The administrative law judge found that this injury arose out of and in the course of his employment and awarded workers' compensation benefits. She also found that the employer/insurer presented no reasonable defense to the claim and awarded assessed attorney's fees. The Appellate Division and the superior court affirmed. The court of appeals granted discretionary appeal and also affirmed.

The court of appeals pointed out that there were very few cases dealing with the presumably broader scope of employment of law enforcement officers. One case which the parties and the court mentioned was *Barge v. City of College Park*, 148 Ga. App. 480 (1978), in which a police officer was murdered for what was believed (although not proved) to be work-related reasons while proceeding from his home to the police station. The murder took place before he entered the city limits of College Park. Nevertheless, the death was found to have arisen in the course of as well as out of his employment.

The court of appeals pointed out that the administrative law judge and the Appellate Division did not award benefits to Negrete merely because he was performing an activity of benefit to his employer. Benefits were awarded because the record clearly revealed that he was performing law enforcement activities at the time of his accident and

injury. The words "of benefit to his employer" were redundant, because any law enforcement activities he performed were certainly of benefit to his employer. The court of appeals also held that the assessment of attorney's fees was proper because this case did not represent an extension of *Barge v. City of College Park*, supra.

In fact, there was a much closer nexus to employment in this case than there was in *Barge*. This case was clearly compensable under general principals of workers' compensation law. The court of appeals ruled that employer/insurer's contention that it could not have reasonably have been expected to anticipate the extension of *Barge* was without any basis in law or fact.

The companion cases of *Gulf States Underwriters of Louisiana v. Bennett*, Ct. App. No. A02A1858, decided February 28, 2003, and *Thomas v. Bennett*, Ct. App. No. A02A1859, decided February 28, 2003, deal with the Board's jurisdiction over entities other than employees, employers, and workers' compensation insurers.

In those cases, the employer was having difficulty securing workers' compensation insurance because of the cost. The employer's insurance agent informed the employer that he had a product that was the equivalent of workers' compensation insurance. This statement was not accurate. The policy referred to its self as an occupational injury policy and specifically stated that it was not a workers' compensation policy. The policy did not provide benefits which were at least equal to those provided under the workers' compensation law. (It provided weekly income benefits not to exceed \$250.00 per week for a period not to exceed 60 weeks and for payment of medical expenses not to exceed \$5,000.00.) When the

employee suffered a compensable injury, Gulf States paid him \$250.00 per week. The employee informed the employer that he should be collecting \$325.00 per week and the employer made up the difference. When Gulf States ceased paying benefits, the employee filed a workers' compensation claim, naming Gulf States and the employer's insurance agent as parties in addition to the employer.

The administrative law judge ruled that the insurance agent was bound by his statement that he was providing a product which was the equivalent of workers' compensation, and was responsible for payment of workers' compensation benefits. Even though Gulf States' policy did not provide benefits at least equal to those under the workers' compensation law, and had not been approved by the State Board of Workers' Compensation, the administrative law judge ruled that the policy was a substitute system under code section 34-9-14 and that Gulf States was responsible for payment of workers' compensation benefits to the employee. The Appellate Division and the superior court affirmed. The court of appeals reversed in both cases. The court of appeals held that the insurance agent was not a party to the claim and that the Board had no jurisdiction over him. The court of appeals further held that the award of benefits against the insurance agent amounted to the award of damages for fraud and stated that the Board did not have jurisdiction to award damages for fraud.

The Board and the workers' compensation system are a creature of statute, and there is no statute authorizing the award of damages for fraud as a workers' compensation benefit. (There are statutes authorizing the imposition of civil and criminal penalties for fraud,

but these penalties are not payable to employees.)

With regard to Gulf States, the court of appeals held that the Board had no jurisdiction over Gulf States. The court pointed out that Gulf States's policy stated on its face that it was not a workers' compensation policy. Because the policy did not provide benefits at least equal to those provided under the workers' compensation law, and because it had not been approved by the Board, it was not a substitute system under code section 34-9-14. Therefore, the Board had no jurisdiction to impose workers' compensation liability on Gulf States.

In *City of Poulan v. Hodge*, 275 Ga. 483 (2002), the supreme court held that a determination that an employee had reached maximum medical improvement was not a legal prerequisite to entitlement to income benefits for permanent partial disability in all cases. The case of *Printpack, Inc. v. Crocker*, Ct. App. No. A0201759, decided March 5, 2003, provides an example of a case in which a finding of maximum medical improvement is not needed. In that case, the employee suffered a hand injury which resulted in the complete amputation of an index finger and the partial amputation of the thumb.

After a period of total disability, he returned to work in August. The employer/insurer did not begin payments of benefits for permanent partial disability until January of the next year. The employer/insurer sought to justify the delay because the employee was not found to have reached maximum medical improvement until December. The employer/insurer delayed the beginning of payment of permanent partial disability benefits despite the requirement of Board

Rule 263 that the employer/insurer have the employee's disability rated within 30 days after the employee returned to work and was no longer entitled to temporary total or temporary partial disability benefits. (That rule provides that benefits are due within 21 days after the employer/insurer receives notice of the rating and presumes that notice is received within ten days of the date of the medical report which establishes the rating.)

The administrative law judge held that in a case of amputation, the loss was established. The amputated member was not going to grow back, and was not going to improve. Therefore, the employer/insurer clearly owed income benefits for loss of the index finger when the employee returned to work and ceased to be entitled to temporary total or temporary partial disability benefits.

It was also obvious that there was a partial loss (not merely a loss of use) of the thumb and the rating for that loss was also due as soon as it was given. The administrative law judge also assessed attorney's fees against the employer/insurer for their unreasonable failure to begin payment of permanent partial disability benefits sooner than they did. The Appellate Division and the superior court affirmed. The court of appeals also affirmed. The court of appeals agreed with the administrative law judge that an amputation was a loss, not merely a loss of use, and that the amputation in and of itself established the existence of a permanent partial disability. The court of appeals held that there was no need to wait for a determination that maximum medical improvement had been reached in order to know the extent of a loss. The court of appeals did acknowledge that a determination that maximum

medical improvement had been reached might well be extremely important in determining the extent of a loss of use, but noted that this case did not involve a mere loss of use.

Therefore, the administrative law judge correctly ruled that the employer/insurer were unreasonable in delaying payment of permanent partial disability benefits in violation of Board Rule 263 merely because there had not been a determination that maximum medical improvement had been reached.

The case of *Willis v. McClain Industries of Georgia, Inc.*, Ct. App. No. A02A2001, decided March 12, 2003 deals with the extent to which an employer/insurer may defend a petition for entry of judgement on a Board award pursuant to code section 34-9-106.

In that case, an administrative law judge awarded income benefits to Willis. There was a valid outstanding lien for child support payments against Willis. The employer/insurer paid the income benefits which the administrative law judge had awarded to the Child Support Recovery Unit to satisfy the lien. Willis filed a petition with the superior court of the county where his injury occurred for entry of judgement against employer/insurer because they had not paid the income benefits awarded to him directly to him.

The employer/insurer defended against the petition based on their contention that they had already paid the award, although they paid the amount to someone other than Willis, i.e., the Child Support Recovery Unit. Employer/insurer contended that the Child Support Recovery Unit was entitled to the money, and that they should not be required to pay the award twice.

The superior court agreed with the employer/insurer and refused to enter judgement.

After granting Willis' application for discretionary appeal, the court of appeals affirmed. The court of appeals held that the employer/insurer were not entitled to relitigate the basic compensability of the claim, but were entitled to defend the petition for judgement on the ground that the award had already been paid, albeit to someone other than the employee who was entitled to receive the money. The court of appeals ruled that there was a significant distinction between a contention that the underlying claim was not compensable and a contention that the benefits awarded had already been paid. The employer/insurer were not authorized to raise the first issue, but were authorized to raise the second.

The case of *Augusta Coca-Cola v. Smalls*, Ct. App. No. A03A0158, decided March 20, 2003, is another in the long string of cases which holds that non-final Board decisions cannot be appealed to the superior courts or the court of appeals. An extensive discussion of the facts of the case is not necessary. It is sufficient to note that the administrative law judge dismissed the employee's claim and the Appellate Division reversed, holding that the employee was entitled to a hearing, and remanded the case to the administrative law judge to hold a hearing. The court of appeals held that the Appellate Division's order was not a final decision and could not be appealed.

The case of *Northwest Georgia Health System, Inc. v. Danner*, Ct. App. No. A02A1104, decided March 24, 2003, deals with compliance with mailing requirements of code section 34-9-221. In that case, the parties reached a settlement of

the employee's claim after mediation. Although the employee's correct mailing address appeared on the caption of the settlement agreement, the employer's servicing agent mailed the settlement check to the employee's former address. The check was mailed from outside Georgia more than three days prior to the expiration of 20 days from the date of the approval of the settlement. The United States Postal Service had a forwarding order in place. Pursuant to that order, the Postal Service rerouted the check to the correct address. The remailing took place inside Georgia prior to the expiration of 20 days from the date of approval of the settlement agreement. The employee did not receive the check until after 20 days had elapsed. The employee contended that the check was not timely paid because it was sent to the wrong address and sought imposition of a 20 percent penalty.

The administrative law judge, the Appellate Division and the superior court granted the request. The majority of the court of appeals reversed. The majority held that substantial compliance with the provisions of code section 34-9-221 that a check mailed within Georgia on or before the 20th day was timely was sufficient. It made no difference that the entity which mailed the check in a timely fashion was the United States Postal Service, not the employer or its servicing agent. The timely action of the Postal Service redeemed the error of the servicing agent. Two judges dissented. They pointed out that code section 34-9-221 required that the employer mail the check in a timely fashion to the correct address. The fact that another entity corrected the error in what would appear to be a timely fashion should not relieve the employer and servicing agent of responsibility for their error.

The case of *American Mobile Imaging, Inc. v. Miles*, Ct. App. No. A03A0018, decided April 15, 2003, deals with the giving of notice of Board hearings by first-class mail.

In that case, the employee requested a hearing on November 21, 2001. The hearing request listed American Mobile Imaging and its insurer, Firemans Fund Insurance Company, as parties. Notice of the hearing was sent to both the employer and insurer at their listed addresses of record. There was no contention that the notices were sent to incorrect addresses. Neither the employer nor the insurer appeared at the hearing. Both later contended that they did not receive notice of the hearing. After the hearing, the administrative law judge issued an award in favor of the employee. The employer and insurer filed a petition in superior court to set aside the award. They contended that lack of notice of the hearing was a

violation of their due process rights and was a non-amendable defect.

The superior court disagreed and denied the petition. The court of appeals affirmed. The court of appeals pointed out that code section 34-9-102(i) required that all parties keep the Board advised of their correct address. That code section further provides that any notice requirement is satisfied by mailing notice to the address of record. The court of appeals pointed out that there was no requirement that the mailing be by certified mail and held that, in the absence of such requirement, mailing by first-class mail was sufficient. The court of appeals further pointed out that the purpose of due process was to apprise parties of the pendency of proceedings and to allow them to present any objections they might have. The court also pointed out that code section 34-9-102(i) emphasized mailing, rather than receipt, of notice.

The court of appeals rejected the employer's argument based on code section 34-9-102(j), that notice to the non-resident employer was not sufficient because it was not sent by certified mail or statutory overnight delivery. The court of appeals pointed out that, while the employer was not a resident of Georgia, the insurer was a resident. Based on the definition of employer found in code section 34-9-1(3) which states that if the employer has secured insurance, the term "employer" includes the insurer, the court of appeals held that notice to either was notice to the other. Therefore, proper notice to the resident insurer was sufficient notice for both the insurer and the employer.

For these reasons, the superior court correctly denied the employer/insurer's petition to set aside the administrative law judge's award. ♦

### Chair's Corner

Continued from page 1

Bennett and Lisa Wade have worked hard to make sure that we will have great food and drink at both events.

The Workers' Compensation for the General Practitioner Seminar was held on March 28. Luanne Clark was in charge and again did a great job in presenting current topics and knowledgeable speakers to educate those who do not regularly practice in the workers' compensation field. Many thanks to Luanne and all of the speakers for their hard work in presenting this informative seminar.

The Workers' Compensation Institute in October 2002 was a great seminar. Steve Welsh of Macon and Nathan Levy of Albany did a fantastic job in putting on the

Institute. The topics they selected were timely, and the speakers they recruited were top notch.

We are continuing to work on a history book about workers' compensation in Georgia. While the initial draft was a good start the Executive Committee felt a more complete picture was needed. After discussing our concerns with the publisher it was agreed that a new writer would be assigned to the project and we are making real progress in putting together a text that will completely and accurately tell the history of workers' compensation in Georgia. We hope to begin soliciting sponsorships and orders for the book in the near future.

I would like to thank all the members of this year's Executive Committee: Doug Bennett, Emily

George, Lee Southwell, Luanne Clark, Tim Hanofee, Shari Miltides, Bob Wharton, and immediate past chair, Mark Gannon. Without all their hard work and dedication, the work of the Section would not get done. I am pleased to announce that N. Staten Bitting, Jr., will be the newest member of the Executive Committee. I know Staten will be a great addition and an asset.

A word of thanks to Carolyn Hall, Chair of the State Board of Workers' Compensation, Directors Viola Drew and Larry Smith, as well as all of the ALJs for their support. I think everyone would agree that we have the most professional, congenial bar of any section in the State Bar, and that all starts at the top. ♦

# O.C.G.A. § 34-9-200(c): Be Careful What You Wish For

BY ANN BAIRD BISHOP AND MARK S. GANNON

Several years ago, representatives of industry were outraged when a handful of administrative decisions were reported to hold that the Employer/Insurer violated the Workers' Compensation Act by scheduling an appointment for an injured worker with the authorized treating physician and asking the injured worker to attend.

In 2002, led by Steve Gilliam of Gainesville, a strong push was made by industry to convince the legislature to amend O.C.G.A. § 34-9-200(c) to allow employers to schedule appointments with authorized doctors and to provide that benefits would be in jeopardy if the employee failed to attend.

The proposed amendment was opposed vigorously by representatives of the claimants, as well as by some physicians. When an amendment to Rule 200, designed to address the stated problem with the proposed amendment attacked, failed to satisfy various industry groups, legislation was introduced, again, in 2003. This time it passed.

Effective July 1, 2003, O.C.G.A. § 34-9-200(c) is rewritten completely. The language of O.C.G.A. § 34-9-200(c), as it exists today and which states that benefits can be suspended or reduced where the employee unreasonably refuses medical treatment is stricken. The new language no longer allows the Board to suspend weekly benefits for failure to cooperate with medical treatment. Instead, all that is

Despite the enthusiastic support of this statutory change by industry groups and despite the fact that the new 2003 statutory provision will give Employers a clear right to schedule appointments for examinations, it is suggested that the new effect may not be as beneficial to either side as one might wish.

required under the new statutory provision is that, as long as he/she is receiving compensation, the employee "shall submit himself or herself to examination by the authorized treating physician at reasonable times... ." Refusal or obstruction of such an examination can result in suspension of benefits unless the Board finds the refusal or obstruction to be justified. The suspension for refusal or obstruction of the examination can only be by order of the Board.

Despite the enthusiastic support of this statutory change by industry groups and despite the fact that the new 2003 statutory provision will give employers a clear right to schedule appointments for examinations, it is suggested that the new effect may not be as beneficial to either side as one might wish.

Representatives of claimants who vehemently objected to any statutory change to allow employers to

schedule appointments with the authorized treating physician, justify attempts to scuttle this amendment by a litany of concerns of possible misuse, abuse, and unintended consequences.

First, and perhaps most justifiably, representatives of injured workers are concerned that having the right to schedule appointments for examination by the authorized treating physician will be misinterpreted by both claims handlers and physicians as ceding the exclusive right to schedule appointments for all authorized treatment to the payer rather than the patient.

Certainly, that is not what the amendment states. By its plain terms, the amendment gives Employers a very limited right to schedule appointments for examinations by the authorized treating physician. The new law does not give the right to employers to schedule authorized treatment or even to schedule appointments with anyone other than the authorized treating physician, e.g., authorized referral doctors or facilities such as physical therapy.

Next, representatives of claimants expressed concern that claims handlers may abuse the right to schedule examinations with the authorized treating physician, scheduling repeated appointments without giving adequate notice, and then using the failure to attend to attempt to justify a suspension of benefits.

Efforts will be made both through

education of physicians and claims professionals and through the Board's rule making authority to ensure that neither of these concerns come to fruition.

The goal of all right thinking participants in the workers' compensation arena must be to allow injured workers to have unimpeded access to the best medical care possible to allow the employee to get the appropriate treatment, facilitate the quickest possible recovery, and return to gainful employment.

As stated in Rule 205(b)(2): "Advance authorization for medical treatment or testing of an injured employee is not required..." Any attempt by doctors' offices or claims handlers to interpose the claims handler between the injured worker and his treating physician in to warranted by the new language of O.C.G.A. § 34-9-200(c) and is contrary to the goal of assuring prompt treatment without

advance authorization or interference. It is hoped that educational efforts will forestall any misconstruction of the purpose and effect of O.C.G.A. § 34-9-200(c), as amended.

An amendment to Rule 200(c) is being proposed in an effort to scotch concerns regarding potential abuse of the new right of employers to schedule appointments for examination by the authorized treating physician. The proposed rule 200(c) will track the existing rule regarding scheduling of independent medical examinations and will require a ten (10) day advance, written notice of any examination by the authorized treating physician requested by the employer, along with pre-payment for travel expenses necessary to enable the injured worker to attend such examination. It is suggested that the notification and advance travel expense requirement will limit the potential for abuse feared

by some representatives of injured workers.

As with previous amendments to the Workers' Compensation Act, the true consequences cannot be immediately known or accurately foreseen. It behooves all parties to work together to expedite the medial treatment for injured workers, which includes proposing no new layers of approval, which includes Claimants actually attending appointments and following up on treatment recommendations. The amendment to O.C.G.A. § 34-9-200(c) gives employers a way to require claimants who are receiving benefits to return to the authorized treating physician for an examination. However, in obtaining this reasonable right, employers gave up the previous right to seek a suspension of benefits where a claimant refuses to cooperate with medical treatment. The effect of this change remains to be seen. ♦

SECOND ANNUAL  
**KIDS' CHANCE INC.**  
**FAMILY FUN FEST**

**Saturday, June 7, 2003**

11 a.m. till 4 p.m.

GEORGIA INTERNATIONAL HORSE PARK  
 CONYERS, GEORGIA

Fun, food & festivities for children of all ages

Box Lunches\* • Adults - \$8/ Kids - \$5

\* Order and prepay in advance. To order contact Karen Cook 404-656-9492

Admission is \$1/person. Tickets for rides and games will be available for purchase at the event. If you or someone you know is interested in becoming a volunteer, please contact:  
 Gloria Cook - 770-403-8651 or 800-848-1989 ext. 1170  
 Celia Carter - 678-417-9117 or 800-552-5198 ext. 227



- |                  |                    |
|------------------|--------------------|
| Pony Rides       | Obstacle Course    |
| Moon Walk        | Bungee Run         |
| Carnival         | Door Prizes        |
| Games            | Gladiator Joust    |
| Bake Sale        | Door Prizes        |
| Little Tyke City | Golf Driving Range |
| Clowns           | Raffles            |
| Petting Zoo      | Super Slide        |
| Face Painting    | Live Entertainment |

# Kids' Chance Chat Room

BY CHERYL OELHAFEN

This past winter provided somewhat of a dry spell for Kids' Chance supporters who enjoy participating in our fundraising events.

The 2002 Fun Run last November, sponsored by the Workers' Compensation Section of the Atlanta Bar Association was hugely successful, thanks to expert coordination by Gregg Porter of Savell & Williams. Gross proceeds of more than \$23,000 came at a good time as spring tuition checks strained our coffers. A big thank you to all sponsors and participants in the 13th Annual Kids' Chance Fun Run!

Our usual Spring Fundraiser - a celebrity roast - has been postponed until the political arena has settled down. Our Seventh Annual Tennis Tournament was held on April 30, chaired by Bridget Kelly of Restore Health Group. She and her team of volunteers did a super job, aided by good weather and great participation from players and sponsors. Gross proceeds totaled more than \$18,700!

And we're happy to report that volunteers put together a Silent Auction at the Atlanta Claims Convention on April 3. Generous donors of auction items and enthusiastic buyers added \$2,500 to the Kids' Chance scholarship fund! The item generating most excitement (along with a lot of oohs and aahs) was a Golden Retriever puppy, purchased by Tom O'Steen of O'Steen Adjusting. Kudos to Gloria Cook (MSC), Holly Fowler (MedNet IMS), Karen Cook (DOAS) and others who gave so much time and energy to organizing the auction. We could not do what we do without our volunteers!

The Kids' Chance Inc. Headquarters in Valdosta has been beautified and upgraded since we received a technology and office furnishings grant from the Robert W. Woodruff Foundation in December. Long-time supporter Howard Osofsky of Bexley & Osofsky law firm in Avondale graciously contributed an impressive piece of artwork by well-known multi-media artist Linda Olds. Thank you Howard, for your friendship and steadfast devotion to our cause.

Our *Serving Up Hope* cookbook continues to generate compliments and sales. If you're interested in ordering or helping us market this outstanding cookbook, please contact our office or Lesli Seta of Speed & Seta law firm in Lawrenceville, who is our Cookbook Coordinator extraordinaire.

At its regional seminars in April, the State Board of Workers' Compensation again offered display space and time on the agenda for Kids' Chance. These meetings provide excellent forums for educating company administrators and employees throughout the state about our unique service offered to children of seriously injured workers. We appreciate the Board's sustaining support. And a huge thank you to GSIA for again including Kids' Chance in its Spring Conference at Brasstown Valley Resort.

Don't forget the Second Annual Family Fun Fest on June 7 at the International Horse Park in

Conyers. It's a terrific day of family fun and you don't want to miss it! Contact Gloria Cook at 800-848-1989 for more information.

And then there's the 11th Annual Kids' Chance Golf Tournament scheduled for July 14 at Wolfcreek Golf Club in Atlanta. Please contact Carole Reich of Caduceus Occupational Medicine for details at 770-642-7810.

The 2003 Fun Run will be held October 25 at Emory's Lullwater Park.

Looking for a hurt to heal...  
a load to lift...  
a problem to solve...  
a need to supply?  
As a partner with Kids' Chance,  
you're doing all these things!

And we'll see many of you at the ICLE Seminar at Sea Palms in St. Simons on October 2. Please let us know if you have items for the Silent Auction and bring your checkbook!

As always the Board, the staff and the families of Kids' Chance, Inc.

are deeply grateful to the members of the Workers' Compensation Law Section. Your commitment to seeing that "our kids" are given the opportunity to achieve their educational dreams is vital to our success. Think of the smiles on the faces of these young people as many of them graduate this spring and move on to college or enter the workplace armed with a degree that will enable them to soar.

In these tough economic times we face many new challenges in meeting our commitments to the children of Georgia's seriously injured workers. We will need your continued support. ♦

# Families of Freedom Scholarship Fund®: Interim Report to Donors

To address the need for long-term educational assistance of the families affected by the September 11th events, Scholarship America<sup>SM</sup> initiated the Families of Freedom Scholarship Fund®.

## Our Name has Changed, Our Mission Remains

Citizens' Scholarship Foundation of America, founder of the Families of Freedom Scholarship Fund®, entered 2003 with a new name: Scholarship America<sup>SM</sup>. We remain steadfast in our mission to expand access to educational opportunities and encourage academic achievement through the Families of Freedom Scholarship Fund (the Fund), providing educational opportunities for postsecondary study to dependents - children and spouses - of those killed or permanently disabled as a result of the September 11, 2001 terrorist attacks, including airplane crew and passengers; World Trade Center and Pentagon visitors and workers; relief workers, including firefighters, emergency personnel; and law enforcement personnel. Scholarship America is expected to administer the Fund through the year 2030.

## Scholarship Funds Raised; No Longer Actively Fundraising

On September 4, 2002, President Bill Clinton and U.S. Senator Bob Dole, co-chairs of the Families of Freedom Scholarship Fund campaign fundraising effort, announced on CNN's *Larry King Live* that Scholarship America's fundraising goal of \$100 million had been met and surpassed. At that time Scholarship America ceased any active fundraising for the Fund. Additional monies collected will allow us to meet a high-

er percentage of the financial need of all eligible students. As of March 2003, available scholarship funds for families of the victims of September 11 have grown to more than \$125 million through the Fund and related programs of the September 11 Scholarship Alliance.

"The dedicated staff and board of Scholarship America are extremely grateful to all the 20,000-plus donors in the United States and throughout the world who responded; to the Lumina Foundation, our partner in launching the Fund; and to President Clinton and Senator Dole for their important backing and valuable assistance," said Scholarship America President William C. Nelson.

## The Students - 185 Scholarship Recipients as of March 2003; Here are Two of their Stories

**Thanbir Ahmed** is a freshman majoring in computer science and business management at St. John's University in Queens, NY, where he is the news anchor for WARD-TV, the university's television station. While Thanbir is perfectly comfortable in front of the camera, he envisions himself working behind the camera. Thanbir has already worked as a production assistant on a full-length, independently-financed feature film called "Games People Play, which he describes as a "genre-bending film mixing comedy, game shows, reality TV and fiction. My work in

pos-production has wrapped and the film is being shopped around through various screenings, and we hope it can catch on at a few film festivals."

Thanbir is thankful for those who gave to the Families of Freedom Scholarship Fund. "I thank them for the compassion and their understanding. My father would be grateful for the opportunities that people I've never met have given me through my education." Thanbir said his father, who was lost on 9/11 while working at Windows on the World, a restaurant atop the north tower of the World Trade Center, "would be grateful that at least something positive - my education - came from the tragedy."

**Amanda Costello** is a junior at Marymount Manhattan College majoring in communication arts. Her father worked at Thyssen Krupp Elevator at the World Trade Center, and the year before 9/11 he had realized his dream when Amanda became the first in her family to attend college. "My parents did not go to college, but they've encouraged me and my younger brother and sister to get an education."

Amanda took a semester off from school to be with her family when she lost her father. "I moved back home and even considered transferring to a school closer to our home in New Jersey," said

Amanda. "Instead, I decided to remain at home *and* return to Marymount by commuting 90 minutes each way." Again a full-time student, she will graduate in the Fall of 2004. Amanda works on Marymount's newspaper, *The Monitor*, where she focuses on design and layout, and also writes news stories. "I'm grateful to the donors whose generosity is helping a lot of families like mine. I haven't yet decided what I will do after college, but I'll have more options thanks to my scholarship."

### Scholarship Awards and Demographics

As of March 2003, the Fund has distributed more than \$1.7 million in educational assistance to 185 students. Scholarship awards range from \$1,000 for students with little or no financial need to \$28,000 per academic year for those with greater need. The average award is \$13,100 per academic year. Estimated distribution for the next five years will be between \$1 million and \$3 million per year, with an average distribution of more than \$4 million annually over the life of the Fund.

The increase in scholarship awards over time is due to the demographics of eligible scholarship recipients, the majority being young children who will not be graduating from high school for several years. Of the 185 scholarship recipients as of March 2003, the majority (157) attend colleges and universities, while the others attend junior colleges, technical or vocation schools. Of the 185 recipients, 18 relate to a firefighter; eight relate to the Port Authority; seven relate to police officers; and two relate to emergency medical technicians. By home state the majority of the scholarship recipients are from New York and New Jersey, but oth-

ers are from California, Connecticut, Florida, Maryland, Pennsylvania, Texas and Virginia. Recipients are pursuing their education in postsecondary institutions in Arizona, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Japan, Kentucky, Massachusetts, Maryland, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Virginia and Washington D.C.

### Continued Outreach to Eligible Families

Scholarship America continues extensive outreach to encourage all eligible families to register regardless of their age, and we also work with other organizations through their outreach events: In February, we anticipated in an outreach event put on by the American Red Cross New England regional office in Boston with 60 families who lost someone on 9/11; in March we met with 250 families in Staten Island at an event put on by St. Clare's WTC Outreach. Another initiative with promising outreach potential was a mailing sent out in February by the Mayor's Office in New York City, which as one of just two copies of the master list of 9/11 victims. As of March 2003, Scholarship America had sent information packets to 1,884 families, and from that efforts, 2,861 individuals have registered, including 1,940 children, 881 spouses and 40 domestic partner relationships. For more information, visit [www.familiesoffreedom.org](http://www.familiesoffreedom.org).

### Families of Freedom 2: Building Futures through Education

Families of Freedom 2 was co-founded by Scholarship America

and the AXA Foundation to provide scholarships for families in Lower Manhattan who suffered loss of income as a direct result of the destruction or impairment of a business located south of Houston Street in Lower Manhattan due to the attacks on the World Trade Center on September 11, 2001. The fundraising goal for Families of Freedom 2 is \$10 million, and as of March 2003, we have raised \$6.8 million toward the goal. The first Families of Freedom 2 scholarships were awarded in January 2003. For more information, visit [www.familiesoffreedom2.org](http://www.familiesoffreedom2.org) and [www.families911.org](http://www.families911.org).

### About Scholarship America (formerly Citizens' Scholarship Foundation of America)

Scholarship America, the nation's largest nonprofit private sector scholarship and education support organization, carries out its mission of expanding access to education opportunities and encouraging academic achievement through its Dollars for Scholars<sup>®</sup>, Scholarship Management Services<sup>™</sup>, and ScholarShop<sup>®</sup> programs. Headquartered in Minneapolis and St. Peter, MN, Scholarship America has distributed more than \$911.5 million to nearly 850,000 students through its scholarship and other support programs since its founding in 1958. For the sixth year in a row, *SmartMoney*, *The Wall Street Journal's* magazine of personal finance, has ranked Scholarship America as one of the 17 most efficient nonprofits in the country. *Worth Magazine* has also named Scholarship America as one of America's 100 best charities for 2001/2002. For more information, visit [www.scholarshipamerica.org](http://www.scholarshipamerica.org). ♦

### Footnotes

continued from page 13

i. Issued by Parashar B. Patel, Deputy Director, Purchasing Policy Group, Center for Medicare Management, Department of Health and Human Services. If the total settlement amount is greater than \$250,000 or if the claimant has already qualified for SSDI disability, Medicare's interest must be considered as part of the settlement.

ii. It is important to note that Set-Aside arrangements are only used in workers' compensation cases that possess commutation (a substitution or exchange) aspect; they are not used in workers' compensation cases that are strictly compromise cases. Lump sum compromise cases are agreements between workers' compensation carriers and claimants to accept less than the claimant would have received

if full reimbursement for benefits and life-time medical treatment expenses. The workers' compensation carrier disputes liability and usually no medical bills have been paid. Commutation cases are settlements intended to compensate claimants for future medical expenses where compromise cases are awards for current or past medical expense. Therefore, regardless whether liability is acknowledged by the carrier for the claim or not, any settlement that intends to compensate a claimant for future medical expenses is a commutation case.

iii. Criteria for evaluation of the proposed settlement and Set-Aside include: type and severity of injury or illness, age of beneficiary, workers' compensation classification of beneficiary (permanent partial, permanent total disability), prior

medical expenses paid, nature and character of anticipated future medical treatment and amount of settlement. Medicare applies these criteria on a case-by-case basis. A Set-Aside arrangement should be funded on the expected life expectancy of the claimant.

iv. The contractor designated to monitor the claimant's case is responsible for verifying that the funds allocated to the Set-Aside arrangement were expended on medical services for Medicare covered expenses only. The contractor will also be responsible for ensuring that Medicare makes no payments related to the worker's compensation injury until the Set-Aside arrangement has been exhausted. Structured Set-Aside arrangements can be a specific sum over a claimant's lifetime or a set amount per year.



## Attention All Section Members!

The State Bar needs your email address! We want to be able to send you section-related information such as newsletters and meeting notices in a fast and efficient manner. If you have not yet submitted your email address to the Bar's Membership Department you may do so online or by emailing [membership@gabar.org](mailto:membership@gabar.org).