Georgia State Board of Workers' Compensation

Procedure Manual

This Procedure Manual is to be used as a reference tool in conjunction with and as an adjunct to Title 34, Chapter 9 of the Official Code of Georgia Annotated and the Rules and Regulations of the State Board of Workers' Compensation. The Procedure Manual is updated annually to reflect any changes in the workers' compensation law or rules. Copies of the Procedure Manual may be obtained on line at the Board's web site at www.sbwc.georgia.gov.

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INSURER/SELF-INSURER REFERENCE SECTION

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Chapter 1

INITIAL PROCESSING OF A CLAIM

Hereafter in this text, "the Board" or "Board" refers to the Georgia State Board of Workers' Compensation. Anyone using a Board form must use the most current revision of the form.

A. Form WC-1 Employer's First Report of Injury or Occupational Disease

The employer completes Form WC-1, Section A of the form immediately upon knowledge of an injury. The employer transfers the WC-1 to the insurer's claims office. The date the insurer receives the report must be clearly stamped on the report. Upon receipt, the insurer checks the report for completeness and accuracy. The insurer must provide all information requested on the form before filing with the Board. If filing on or after July 1, 2010, the WC-1 must be filed EDI (Electronic Date Interchange), see Chapter 5.

1. The insurer files Form WC-1 with the Board when:

    a. an injured employee loses more than seven calendar days from work;
    b. an injured employee loses wages entitling him or her to temporary partial disability;
    c. an injured employee has permanent disability;
    d. an employee dies;
    e. an insurer controverts the claim in whole or in part;
    f. an injured employee or attorney representing an injured employee files a claim, WC-14, *Notice of Claim/Request for Hearing/Request for Mediation*, if not previously filed;
    g. catastrophic injury is accepted as compensable (file within 48 hours of acceptance);
    h. a stipulated settlement is filed; attach a copy of Form WC-1 for each date of accident covered by the settlement;
    i. a change of physician or treatment is requested for a “Medical Only” case (file along with Form WC-200b).

2. The insurer completes Section B, C or D and files the original with the Board and sends a copy to the employee within 21 days of the date of injury or the employer's knowledge of disability. Failure of a report to reach the Board within 21 days from employer's knowledge may result in a penalty (see Board Rule 221(d).

3. Employee’s social security number and date of injury are required on Form WC-1 to create a file at the Board. If SSN is not available, the WC-1 can not be filed electronically and must be filed in paper. The insurer’s claims office is responsible for submitting a completed report.

4. Form WC-1 must show the complete name, address, and FEIN (Federal Employer Identification Number) of the employer.

5. The complete name of the insurer along with the name and the address of the claims office must be shown.

6. The SBWC ID # is mandatory; it is a five-digit # that is assigned by the Board (see Board website www.sbwc.georgia.gov for SBWC ID #).

7. Form WC-1 should include identification of treatment. Check the box which best describes the source of the medical care provided.

8. If there is an insurer's file number, it should be used on all documents.

B. Form WC-1 Section A

Upon receipt of Form WC-1, the insurer/claims office must check to see that the employer has completed all questions in Section A. The insurer/claims office must complete any unanswered questions on the form.

C. Form WC-1 Section B

Section B of Form WC-1 is used to commence weekly benefits or to suspend weekly benefits when the employee has actually returned to work at the time Form WC-1 is filed with the Board. In all other cases, the insurer should file Form WC-2. The insurer must furnish a copy to the claimant [see Board Rule 61(b) (1)].

1. The insurer must show payment of maximum benefits unless a Form WC-6, wage statement, is attached [see Board Rules 221(c) and 61(b) (6)].

2. Benefits for temporary total disability are payable from the eighth day of disability. The seven-day waiting period is computed as follows:

   The date of disability is the first day the employee is unable to work a full day. If, however, the employee is paid in full for the date of injury, the date of disability begins the next day following the date of injury. The day or days considered lost because of disability to work are counted from the first seven days of disability even though the days may not be scheduled workdays. For example, if an employee, who is normally not at work on Saturday and Sunday, is injured on Thursday and is unable to work Friday, the following Saturday and Sunday must be counted as two days of the waiting period. Entitlement to benefits for the first seven days of disability, or any part thereof, requires 21 consecutive days of disability. The employer/insurer shall pay compensation for the first seven days of disability on the 21st consecutive day of disability (see Board Rule 220.)

3. The insurer must fill in the date of first payment of income benefits.

a. The first payment of income benefits is due on the 21st day after the employer has knowledge of the injury or death, on which day all income benefits then due shall be paid. Thereafter, income benefits shall be due and payable in weekly installments.

b. Weekly payments are considered paid when due when mailed from within the State of Georgia to the address specified by the employee or to the address of record according to the Board. Payments may also be made by electronic transfer of funds by agreement of the parties. Such payment will be considered to be paid when due at the time they are made by electronic funds transfer to an account specified by the employee.

c. Payments mailed from outside the State of Georgia are considered paid when due when mailed no later than three days prior to the due date to the address specified by the employee or the address of record according to the Board. Payments may also be made by electronic transfer of funds by agreement of the parties. Such payment will be considered to be paid when due at the time they are made by electronic funds transfer to an account specified by the employee.

d. If income benefits due without an award are not paid when due, a 15% penalty must be paid at the same time. The penalty is in addition to the accrued benefits.

4. The insurer must show the amount of compensation or the date salary was paid and the amount of any late payment penalty paid at the time of the first payment. Also, indicate whether or not the claim was previously medical only.

5. Indicate the type of weekly income benefits paid.

   a. Temporary total disability (O.C.G.A. §34-9-261).
   b. Temporary partial disability (O.C.G.A. §34-9-262).
   c. Permanent partial disability (include disability rating, part of body, number of weeks, and attach a copy of the medical report establishing the rating (O.C.G.A. §34-9-263).
   d. Weekly death benefits must be commenced on Form WC-2a (see Chapter 2).

6. The date of suspension must be shown when it is known that the employee has returned to work without restrictions.

D. Form WC-1 Section C

Section C of Form WC-1 is used to controvert, in whole or in part, the right to compensation or other benefits. The insurer must complete Section C to controvert and must state the specific grounds on which the case is controverted. Furnish a copy to the employee and any other person with a financial interest in the claim.

E. Form WC-1 Section D

The insurer must complete Section D for medical-only injuries where no indemnity benefits have been paid or the claim has not been controverted. Complete Section D if a WC-14 has been filed on medical only. Complete Section D if a medical-only claim has been settled. Complete Section D if filing a WC-200a. Electronic filing is not permitted for Section D or Medical Only Claims of the WC-1; it must be filed in paper.

F. Form WC-6 Wage Statement

1. Requirements for filing with the Board:

   The insurer must file this form when the weekly benefit is less than the maximum under O.C.G.A. §34-9-261 or §34-9-262.

   Forms WC-1, WC-2, WC-2a, or WC-4 must show payment of maximum weekly benefits under O.C.G.A. §34-9-261 or §34-9-262, as applicable, unless Form WC-6 is already on file.

2. Average weekly wage computation:

   a. Computation of wages shall include, in addition to salary or hourly pay or tips, the reasonable value of food, housing, and other benefits furnished by the employer without charge to the employee which constitute a financial benefit to the employee and are capable of monetary calculation [Rule 260(a)].
   b. If the employee has similar concurrent employment, the wages paid by all similar concurrent employers must be included in calculating the average weekly wage. If the concurrent employment is of the same general nature, it is similar. For example, a record clerk and a sales clerk are similar employment.

3. If a party makes a written request of the employer/insurer, then the employer must send the requesting party a copy of the completed Form WC-6 within 30 days.

G. Methods of Computation

1. The employer/insurer must use the 13 weeks immediately preceding the injury. The employee must have worked substantially the whole of the 13 weeks to compute the wage under O.C.G.A. §34-9-260(1).

2. If the employee has not worked substantially the whole of 13 weeks immediately preceding the injury, the employer/insurer must use the wages of a similar employee in the same employment who has worked substantially the whole of 13 weeks preceding the injury. The employer/insurer must indicate on Form WC-6 if wages provided are those of the injured employee or a similar employee [O.C.G.A. §34-9-260(2)].

3. If the 13-week wage statement of the injured employee or a similar employee cannot reasonably and fairly be applied, the employer/insurer must use the full-time weekly wage of the injured employee [O.C.G.A. §34-9-260(3)].

H. Fractional Part of Week

It is assumed that a normal work week is five days, that the normal workday is eight hours, and that the employee's daily wage is one-fifth of the weekly pay. Fractional parts of a day shall be credited proportionally in computing the daily wage. For example, the daily wage of a five-and-one-half day worker is the weekly wage divided by 5.5.

*NOTE: Use Form 262 for documentation of payments every 13 weeks or when Form WC-2 is filed, whichever occurs first.

I. Form WC-26 Yearly Report of Medical Only Cases and Annual Payments of Indemnity Claims

1. Filing requirements with the Board:

   The Insurer, Self-Insurer or Group Fund must file Form WC-26 to report payments made on medical only and indemnity claims during the previous calendar. This report is a consolidation of payments by the Insurer or Self-Insurer or Group Fund, due on or before March the 31st following the end of each calendar year. File annually even if no reportable injuries or payment occurred during the reporting year.

2. Completing Form WC-26:
   Section A
   a. Name of insurer or self-insurer or Group Fund:
      Show individual insurer's name, not the name of insurance group or Claims Office/TPA. Self-insurers and group fund use name as it appears on the self-insurance permit. Group Fund uses the Group Fund name not the individual member's name.

   b. The SBWC ID # is mandatory; it is a five-digit # that is assigned by the Board (see Board website www.sbwc.georgia.gov for SBWC ID #).

   c. Year of report: Use the calendar year in which the medical expenses are paid. File by the 31st day of March following the end of the calendar year. File even if no reportable injuries or payments occurred during the calendar year.

   Section B – Medical Only Claims
   a. Total number of new medical-only injuries for the calendar year:
      If no new injuries were reported, enter "0".

b. Total amount of medical paid on medical-only injuries during calendar year regardless of the date of injury:
DO NOT INCLUDE MEDICAL PAYMENTS REPORTED ON FORM WC-4, CASE PROGRESS REPORT.
If no medical-only payments were made, enter "0".

Section C – Indemnity Claims

a. Total amount paid on indemnity claims this year regardless of the date of injury.
b. Total number of new indemnity cases reported during the calendar year.
c. Total amount paid on Temporary Total Benefits this year regardless of the date of injury.
d. Total amount paid on Temporary Partial Benefits this year regardless of the date of injury.
e. Total amount paid on Permanent Partial Benefits this year regardless of the date of injury.
f. Total Medical paid on indemnity claims this year (do not include the hospital payments).
g. Total Hospital paid on indemnity claims this year.
h. Provide the name, address and telephone number of the person submitting the report.

References: O.C.G.A. §34-9-108
§34-9-221
§34-9-260
§34-9-261
§34-9-262
§34-9-263

Board Rules 15, 61, 200, 220, 221, 260, 262, 263

Chapter 2

DEATH CLAIMS

A. Form WC-1 Employer's First Report of Injury or Occupational Disease and Form WC-2a Notice of Payment or Suspension of Death Benefits

The requirements for completing and filing Form WC-1 in a death case are the same as in a lost-time case. The employer/insurer must also submit Form WC-2a. If the WC-1 is filed EDI, form WC-2a must be filed EDI (SROI), see Chapter 5.

The information on Form WC-2a should always show date of birth, not age, and the relationship of all dependents to the deceased employee.

A determination of whether a death is compensable is, in general, the same as a determination of whether an injury or disease is compensable. If the injury or disease which caused death is compensable, then the death is compensable.

An employee who dies, or is found in a dying condition at work, or in a place where he or she is supposed to be while working, is considered to have died from an injury or disease arising out of and in the course of employment until it is proved otherwise.

B. Beneficiaries and Guardians

According to the 1985 Amendments to the Workers' Compensation Act, a surviving spouse is conclusively presumed totally dependent on the deceased employee for support. However, beginning July 1, 2000, the presumption can only be rebutted by evidence showing that the wife and husband were living separately for at least 90 days immediately prior to the injury which resulted in the death of the deceased employee. Between 1985 and July 1, 2000, the presumption was rebuttable if the surviving spouse was employed for at least 90 days prior to the injury which resulted in the death of the deceased employee. In determining whether the presumption is rebutted in a particular case, reference should be made to the case of Insurance Company of North America v. Russell, 246 Ga. 269(1980). This case set a standard for determining the dependency of a surviving spouse. According to the standard, a surviving spouse who was dependent on the deceased spouse for support in whole or in part or was in need of such support qualifies as a total dependent of the deceased spouse. Since 1985 it can no longer be said that this standard can be used to establish a conclusive presumption of total dependency. Jones v. Winners Corporation, 189 Ga.App.875 (1989). The mere fact that no money changed hands between the surviving and deceased spouse does not in and of itself rebut the presumption of dependency. It is possible that evidence which shows both incomes were necessary to maintain the couple's life-style may be sufficient to support a finding that the presumption of total dependency has not been rebutted. It has been held that where the surviving spouse earned nearly as much as the deceased spouse and had substantial sources of support from other household members, the presumption of total dependency was rebutted. Goode Brother Poultry Company v. Kin, 201 Ga.App.557 (1991). Whether the holding is

limited to the particular facts of the case or whether that means the presumption is rebutted as a matter of law if the surviving spouse has any earnings at all for three months prior to the deceased spouse's death is not clear from the Kin opinion.

The absence of proof of a ceremonial marriage of one claiming to be a surviving spouse does not automatically reject consideration. However, after January 1, 1997 the state of Georgia will no longer recognize common-law marriage which might impact claims for injuries occurring after that date.[1]

The marriage of a surviving spouse terminates entitlement to income benefits.

Cohabitation in a meretricious relationship also terminates the dependency of a surviving spouse. Cohabitation in a meretricious relationship as defined by law is two persons of the opposite sex living together continuously and openly in a relationship similar to marriage. See O.C.G.A §34-9-13(e). The employer/insurer may terminate dependency benefits on the basis of a meretricious relationship only by order of the Board.

A child conclusively presumed to be dependent is any of the following:

1. A legitimate natural child, under age 18 or enrolled full time in high school, and unmarried at time of the injury or disease causing death of the employee.

2. An acknowledged illegitimate natural child, under age 18 or enrolled full time in high school, and unmarried at time of the injury or disease causing death of the employee.

3. A step-child, under age 18 or enrolled full time in high school, and unmarried at time of the injury or disease causing death of the employee, if the step-child was actually dependent on the deceased employee for support at the time of the injury or disease causing death.

4. A legally adopted child, under age 18 or enrolled full time in high school, and unmarried, whose adoption had become final at time of the injury or disease causing death of the employee.

5. A posthumous child.

6. A child described above, but between the ages of 18 and 22 and a full-time student in a postsecondary institution of higher learning.

7. A child described above, but over age 18 and physically or mentally incapable of self-support at time of injury or disease causing death of the employee.

[1]O.C.G.A. §19-3-1.1 with passage of this law the state of Georgia will not recognize common-law marriages after January 1, 1997.

A child married at the time of the injury or disease causing death does not qualify as one conclusively presumed dependent.

Upon reaching age 18 the dependency of a child terminates, unless the child is enrolled full time in high school or the child was physically or mentally incapacitated from earning a livelihood at the time of the injury or disease causing death of the employee. A child's dependency continues until age 22 if the child is and remains enrolled as a full-time student in a recognized educational institution. There is nothing in the statute to terminate benefits to a child who marries after the date of the injury or disease causing death.

In all other cases whether a person is wholly or partially dependent must be shown by facts establishing actual support in existence at the time of the injury or disease, which caused death, and for a period at least three months prior to the accident.

As long as at least one person is wholly dependent under any of the above situations, persons partially dependent are not entitled to benefits. When no person qualifies as wholly dependent, and there is a balance of income benefits available, any person or persons partially dependent are entitled to income benefits. Partial dependents share benefits among themselves according to the relative extent of their dependency.

Parents include natural parents, stepparents, and adoptive parents.

A surviving spouse with a child or children, if any, qualifying as dependents, is entitled to receive benefits for his or her use, if he or she qualifies as a dependent, and for the use of any child or children who qualify as dependents, unless the Board apportions otherwise. Ordinarily, there is no reason for apportionment, except where dependent children reside in different households. Without exception, if there is any apportionment, it is based on equal shares to or for the benefits of persons wholly dependent.

Between July 1, 1996, and June 30, 1999, the only person capable of representing a minor or legally incompetent claimant entitled to workers' compensation benefits shall be a guardian duly appointed and qualified by the probate court of the county of residence of such minor or legally incompetent person. Said guardian shall be required to file with the Board a copy of the guardianship returns filed annually with the probate court and give notice to all parties within 30 days of any change in status.

After July 1, 1999, O.C.G.A. §34-9-226 provides that the Board may appoint guardians for minors or legally incompetent adults under the following limited circumstances:

1. receipt and administration of benefits not to exceed 52 weeks, subject to renewal or extension by order of the Board;

2. to compromise and terminate any claims and receive any sum paid in settlement approved by the Board that does not exceed $50,000; and

3. when there is no guardian for minor or incompetent adult, the Board may appoint a temporary guardian ad litem not to exceed 52 weeks to bring or defend an action under the Workers' Compensation Act.

Forms WC-226 (a) and WC-226 (b) may be used by guardianship petitioners.

C. Death Benefits

Benefits arising from a compensable death consist of the following:

1. The reasonable expenses of the employee's last sickness;

2. Burial expenses not to exceed $7,500;

3. Weekly income benefits for dependents are computed on the same basis as for total disability. Benefits are payable to a surviving spouse or a partial dependent until age 65 or 400 weeks, whichever is greater, and to a child until age 18 or age 22 if a full-time student in a recognized educational institution. For injuries occurring prior to July 1, 1995, there is a limit of $1,000 if all dependents are not citizens or residents of the United States or Canada. There is a limit of $150,000 if the only dependent at the end of one year from the date of death is the surviving spouse.

4. For injuries occurring prior to July 1, 1995, if there are no dependents, a payment is made to the Subsequent Injury Trust Fund. For injuries occurring on or after July 1, 1995, if there are no dependents, a payment is made to the State Board of Workers' Compensation, which is then remitted to the general fund of the state treasury.

The reasonable expenses of the employee's last sickness should be paid directly to the providers of these services. The burial expenses, up to the limit of $7,500, should be paid directly to the provider of these services. Payment to a person other than the provider of the above services can create problems, particularly if more than one person helped pay for services. For example, burial services costing more than $7,500 paid by several relatives. In such a situation, the employer/insurer should request instructions from the Board unless the parties agree on a distribution.

The proper claimant for medical or burial expenses is the supplier of the services, the legal representative of the estate, or another who has actually paid for the services. An employer or insurer making payment for the services directly to a surviving spouse, unless the survivor actually paid for the services or is the legal representative of the estate, does so at the risk of being required to make a second payment to the rightful party.

Persons wholly dependent are entitled to equal benefits. For example, in the case of a surviving dependent spouse with two dependent minor children and a former spouse with one dependent minor child; dividing the maximum benefit equally among the four dependents, each is entitled to $125.00. Thus, the surviving spouse with two children would get $375.00 for his or her use

and the use of the two children, and the former spouse would get $125.00 for the use of the minor child. When any child reaches age 18 and up to age 22 if not enrolled full-time in a postsecondary institution of higher learning or high school, benefits terminate, and the amount payable to the other dependents would increase.

The weekly benefit for any person partially dependent is determined by the following formula: Weekly contribution for support divided by average weekly wage times benefit payable to a person wholly dependent.

As an example, a deceased employee had an average weekly wage of $600 and contributed $150 weekly to help support her mother. The benefit amount for the mother is determined as follows:

$$\$150 \div \$600 \times \$500 = \$125.00$$

Where there are several claimants for income benefits, and no doubt exists as to the entitlement of one or more, but the determination of others requires more investigation or litigation, payment to a recognized claimant in the least amount that claimant would receive, with explanation that it may be adjusted upward later, is proper. For example, there is a surviving spouse and minor child who are admittedly due benefits, and a claim on behalf of a child born out of wedlock probably can be resolved only after litigation. In this example the insurer makes payment of two-thirds of the income benefits to the surviving spouse for the use of the spouse and child, with explanation and accompanying forms furnished to the claimant. The insurer should place the remaining one-third in an escrow account until resolution of this litigation.

In cases where there are no dependents, the benefit payable to the State Board of Workers' Compensation is one-half of the amount that would have been payable to a person wholly dependent, if one had existed, or $10,000, whichever is lower. If, after payment has been made, it is determined that a dependent or dependents qualified to receive benefits exist, then the insurer or self-insurer shall be entitled to reimbursement by refund for moneys collected in error.

References: O.C.G.A. §34-9-13
§34-9-225
§34-9-226
§34-9-265
§34-9-281

Board Rules 61(b) (1, 3), 226

Chapter 3

SUBSEQUENT CLAIM PROCESSING

A. Suspension of Income Benefits - Forms WC-2 and WC-3

1. Unilateral Suspension by Insurer

The first use of Form WC-2 (Notice of Payment or Suspension of Benefits) is to suspend the weekly benefit payment when a change in disability status occurs after Form WC-1 has been properly filed with the Board. The form is used to notify the employee and the Board of suspension of income benefits. Form WC-2 is the proper form to report any change in income benefits, classification, or rating of disability. Form WC-3 (Notice to Controvert) is intended to deny liability in whole, or in part, after Form WC-1 has been filed with the Board, and serves the same purpose as Section C of Form WC-1. If Form WC-1 is filed by EDI then subsequent Form WC-2 and Form WC-3 must be filed EDI (SROI) also, see Chapter 5.

For suspension of income benefits, the insurer/self-insurer file Form WC-2 with the Board, and where needed a Form WC-3 or other documents as stated below, and furnish a copy to the employee when:

a. The employee returns to work for the same or another employer at a wage equal to or exceeding the average weekly wage at the time of the disabling injury.

b. The employee is released to return to work without restrictions. The insurer/self-insurer must attach supporting medical information from the authorized treating physician to the Form WC-2 filed with the Board. The insurer/self-insurer must give the employee ten days advance notice of the suspension of income benefits. Unless there is compelling evidence to the contrary, the date stamped by the Board as its date of receipt is deemed to be the date the employee received notice.

c. The employee is released to return to work with restrictions and the employee refuses to attempt to perform a suitable job when the requirements of Board Rule 240 are met.

d. The employee dies. The insurer/self-insurer must furnish a copy of the Form WC-2A to the representative of the estate of the deceased employee, if known, and attach a copy of the death certificate, if available. If the insurer/self-insurer contends that the death is unrelated to the injury, a Form WC-3 should accompany the Form WC-2.

e. If, within 60 days after the due date of the first payment of income benefits (which is 21 days after the employer's notice or knowledge of a lost-time disabling injury or disease), the insurer/self-insurer makes the determination to controvert the payment of income benefits for any reason, a Form WC-3 must be filed with the Form WC-2. The insurer/self-insurer must furnish a copy of the Form WC-3 to all persons having a financial interest. To meet the 60-day deadline the documents must be filed with the

Board, as shown by the Board's filed date, within 60 days after the due date of the first payment of income benefits.

f. If, more than 60 days after the due date of the first payment of income benefits (which is 21 days after the employer's notice of a lost-time disabling injury or disease), the insurer/self-insurer makes the determination to controvert on the basis of newly discovered evidence, Forms WC-3 and WC-2 must be filed with the Board. While not stated in Board Rule 221, the law requires that the insurer/self-insurer give the employee 10 days advance notice of the suspension of income benefits. The insurer must furnish a copy of Form WC-3 to all persons having a financial interest.

2. Board Order or Award to Suspend

When an Administrative Law Judge or the Board issues an order or award suspending benefits, the order or award is transmitted to the address of record of all interested parties and provides authority and notice of the suspension. The basis for a Board ordered suspension of income benefits may include any of the following:

a. The refusal of an employee to accept available work suitable to the employee's capacity to work. This most commonly arises when the authorized treating physician limits the employee to light duty work, and the employer undertakes to provide suitable light duty work. Board Rule 240 sets forth the procedures to follow to effectuate the suspension of income benefits.

b. The refusal of an employee to submit to treatment. O.C.G.A. §34-9-200 and 200.1 specify treatment as medical, surgical, hospital care, vocational rehabilitation, or other treatment provided by the law. Board Rules 200(d) and 200.1(h) permit suspension of income benefits only by order of the Board.

c. The refusal of an employee to submit to a medical examination. Board Rule 202(d) permits suspension of income benefits only by order of the Board.

d. A change in the employee’s condition for the better.

B. <u>Changing Benefits from Temporary Total to Temporary Partial</u>

When the authorized treating physician has released the employee to return to work with restrictions or limitations as required by O.C.G.A. §34-9-104(a) and the injury is not catastrophic, the insurer/self-insurer must complete Form WC-104 (do not send a copy of the WC-104 to the Board at this time). The Form WC-104 must be received by the employee or by counsel for the employee within 60 days of the release to return to restricted work by the authorized treating physician. If the employee has not returned to work within 52 consecutive weeks or 78 aggregate weeks, the insurer/self-insurer are authorized to file a Form WC-2 and a copy of Form WC-104 to change weekly disability benefits from temporary total to

temporary partial disability. Section B.5 on Form WC-2 must specify that the employee's injury is not catastrophic.

For the purposes of calculating temporary partial benefits as contemplated by Code Section 34-9-104(a), benefits shall be paid as follows:

1. When an employee is receiving the maximum benefits for temporary total disability, under Code Section 34-9-261, the employer shall cause to be paid to the employee an amount equal to the maximum benefit allowed for temporary partial disability, under Code Section 34-9-262; or

2. When an employee is receiving less than the maximum allowed for temporary total disability, the employer shall continue to pay the employee the same benefits as provided by Code Section 34-9-261, not to exceed the maximum benefit provided for temporary partial disability, under Code Section 34-9-262.

C. Forms WC-2 and WC-3 Information Required

1. Form WC-2 - Section A

   a. Provide complete information as requested. The most common omissions are the Board Claim #, SBWC ID #, employee's social security number, the date of accident, and the telephone number of the claims administrator.

   b. Show individual insurer/self-insurer's name, SBWC ID #, as well as claims office name, address, and telephone number.

2. Form WC-2 – The Body of the Form

   a. If income benefits are being paid, show last name, first name and middle initial of the person receiving benefits.

   b. Complete weekly income benefit and average weekly wage. If the weekly income benefit is less than the maximum amount of temporary total disability benefits allowed by law, send a Form WC-6 along with Form WC-2, unless previously filed.

   c. Show the "date benefits are payable from" as the date of disability. If the waiting period is not payable, show the date as the eighth day of lost time after disability.

   d. Check the type of disability, and provide the permanent partial disability rating if applicable.

   e. Show the date of the first check as the date the payment is mailed or made to the employee or the date salary was paid instead of weekly benefits. Timely payments must be mailed from within the State of Georgia by the due date, which is 21 days after the employer's knowledge or notice of lost-time disability. Timely payment

made from outside the State of Georgia must be mailed no later than three days prior to the due date.

f. Show the total amount paid and indicate the percentage and amount of any late payment penalties.

2.1 Part B of Form WC-2

a. The effective date of suspension is the date the event occurs which authorizes suspension, except for the 10-day notice to the employee when it is determined that the employee is able to return to normal-duty work, but has not returned to work.

b. The reason for suspension of weekly disability should be indicated, and will be one of the following:

(1) Return to work without restriction from authorized treating physician.

(2) Return to work with restrictions from authorized treating physician at pre-injury rate of pay or higher.

(3) Return to work with restrictions from authorized treating physician at reduced rate of pay, and temporary partial disability benefits are shown in part A. above.

(4) The employee was able to return to work without restriction from authorized treating physician, and the employee has been given a 10-day notice. In EDI, the Physician report must be simultaneously mailed to the Board at the time a SROI is filed.

(5) Employee has undergone a change in condition pursuant to O.C.G.A. §34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release.

(6) Temporary partial disability benefits are shown above in part A. In EDI, a copy of the Form WC-104 must be simultaneously mailed to the Board at the time the SROI is filed.

(7) Employee has been offered suitable employment pursuant to O.C.G.A. §34-9-240 and has unjustifiably refused to attempt to perform the job. Form WC-240 was sent at least ten days before the employee was required to report for work. In EDI, a copy of the Form WC-240 must be simultaneously mailed to the Board at the time the SROI is filed.

(8) This was not a catastrophic injury, and the maximum number of temporary total disability payments has been paid.

(9) The entire permanent partial disability benefit has been paid.

(10) The entire number of temporary partial disability payments has been paid.

(11) Claim is being controverted within sixty days of the due date of the first payment. The Form WC-3 must be filed with the Board and a copy sent to the employee.

(12) Other.

3. Form WC-3 - The Body of the Form

   a. State the reason(s) why liability is being controverted in whole or in part. General statements to the effect that "liability is not being accepted pending investigation" or "the right is reserved to controvert on further grounds" alone are not acceptable. The employee or potential beneficiary is entitled to know precisely why and to what extent the claim is being controverted.

   b. List the distribution in the space provided and furnish copies to the employee and any other person with a financial interest in the claim including, but not limited to, the treating physicians and attorneys in the claim.

D. Recurring Total and Temporary Partial Disability

Where liability is accepted to pay weekly income benefits and a Form WC-1 has been filed, Form WC-2 is used to show the commencement and suspension of benefits as the events occur. The events and procedures to effect suspension are covered in Chapter 3, Section A. Form WC-2 is used to commence weekly income benefits for recurring disability when:

1. The employee ceases to work for the same or another employer because of the work-related injury, which constitutes a change in condition and not a new accident. An economic loss of wages due to the work-related injury must occur, and this economic loss ordinarily takes place when there is a gradual deterioration of physical condition resulting from the injury, which may or may not be attributable to working conditions subsequent to the injury.

   A frequent area of litigation (particularly if one employer and two insurers are involved or if two employers and two insurers are involved) is whether the inability to continue working involves reinstatement of benefits as a change in condition, or whether it is a condition to be treated as a new accident. Consequently, general guidelines only are stated herein, primarily to guide the investigator before seeking legal advice. The questions below will produce facts on which to reach a decision:

a. Is the disability to work due to a gradual deterioration, but not the result of any specific incident at work? If the answer is affirmative, it is likely that a change in condition has occurred.

b. Is the disability to work due to an aggravation of injury by conditions while working for the same employer, but not because of any specific incident? If the answer is affirmative, it is likely that a change in condition has occurred.

c. Is the disability to work due to an aggravation of the injury while working for another employer? Did the new job involve changed work duties which bear some relationship to the present disability to work? Was there a specific incident while working on the new job which bears some relationship to the disability to work? An affirmative answer to any of these questions is indicative of a new accident instead of a change in condition.

2. The employee ceases to work for the same or another employer because of medical treatment including, but not limited to, therapy, surgery, hospitalization, or medical examination resulting from the work-related injury.

3. The employee ceases to work for the same or another employer and is unable to find any suitable work because of an impaired condition resulting from the work-related injury.

4. The employee, although working for the same or another employer, is unable to earn as much or more than his or her average weekly wage at the time of the disabling injury, subject to all of the following conditions:

   a. The economic partial loss of earnings results from the work-related injury. This may be due to limitations imposed by the authorized treating physician involving lifting, movement, number of hours, or due to the lack of suitable work;

   b. The economic partial loss of earnings occurs within 350 weeks from the date of injury; and

   c. The economic partial loss of earnings is a temporary situation. This is the most frequently overlooked condition to determine whether an employee is entitled to temporary partial disability benefits based on a partial loss of earnings, or permanent partial disability based on a permanent physical impairment. The partial wage loss is defined in the law as a disability to work partial in character and temporary in quality. Thus, if the partial wage loss is one which is a permanent loss, it does not meet the requisite temporary quality. Whether to treat the loss as temporary or permanent depends upon a careful evaluation of various factors, including:

      (1) Whether the impairment has reached maximum improvement and whether it temporarily or permanently affects earnings ability.

(2) Whether normal seniority job promotions, vocational rehabilitation training, experience or other variables will cause the employee in the future to increase earnings to the level of the average weekly wage at the time of injury.

E. Permanent Partial Disability

1. Entitlement

Form WC-2 is used to commence income benefits for permanent partial disability or to change classification of income benefits to permanent partial disability benefits. The conditions which entitle an employee to permanent partial disability income benefits include all of the following:

a. Not entitled to income benefits for total disability to work.

b. Not entitled to income benefits for temporary partial disability to work.

c. A permanent impairment exists attributable to work-related injury involving the loss of, or the loss of use of, a body member or the whole person as listed in the schedule in O.C.G.A. §34-9-263 or entitlement for occupational loss of hearing under O.C.G.A. §34-9-264.

2. Determination of Loss of or Loss of Use of a Body Member

The determination of the extent of the loss is made by the authorized treating physician and stated in terms of disability to the particular member injured or the whole person. The disability is not a disability to work, but is a physical disability, perhaps better understood if thought of in terms of impairment.

The percentage of loss or status for certain conditions listed in O.C.G.A. §34-9-263 is controlled by law. These are:

a. Impairment ratings. In all cases arising under this Chapter, any percentage of disability or bodily loss ratings shall be based upon Guides to the Evaluation of Permanent Impairment, fifth edition, published by the American Medical Association.

b. Loss of more than one major member. Loss of arms, hands, legs, or feet, or any two or more of these members, or the permanent total loss of vision in both eyes shall create a rebuttable presumption of compensable permanent total disability.

References: O.C.G.A. §34-9-1
§34-9-104
§34-9-200
§34-9-200.1
§34-9-220

§34-9-221
§34-9-240
§34-9-260
§34-9-261
§34-9-262
§34-9-263

Board Rules 61(b) (2, 3), 104, 200, 200.1, 221(c, d, e, h, i), 220, 221, 240, 263

Chapter 4

THE CASE PROGRESS REPORT (FORM WC-4)

A. General

The Board uses Form WC-4 for periodic review of a claim. It is the basis for benefit cost collected by the Board. Filing Form WC-4 as required by Board rules enables the Board to close cases promptly and provides accurate and current benefit cost figures.

B. Filing Guidelines

Form WC-4 is required in all cases in which a Form WC-14 (Notice of Claim or Request for Hearing/Mediation) or Form WC-1 is filed with the Board. The employer/insurer should use the following guidelines:

1. Board rules require filing as follows:

    a. Within 180 days of the first date of disability;
    b. Within 30 days from last payment for closure;
    c. Upon request of the Board;
    d. Every 12 months from the date of the last filing of a WC-4 on all open cases;
    e. To reopen a case;
    f. Within 30 days of final payment made pursuant to an approved settlement.
    g. Within 90 days of receipt of an open case by the new third party administrator.

2. File a reopened Form WC-4 to show additional payments on previously closed cases or when an employee requests a hearing on a previously closed claim.

3. Form WC-4 should always indicate whether it is an initial, supplemental, final or reopened report.

4. The top section should show the Board claim number along with the name of employee, social security number and date of injury.

5. Show the type and amount of income benefits paid at the time the report is filed.

    a. Temporary total disability income payments under O.C.G.A. §34-9-261.

    b. Temporary partial disability income payments under O.C.G.A. §34-9-262.
    *NOTE: Use Form 262 for documentation of payments every 13 weeks or when Form WC-2 is filed, whichever occurs first.

c. Permanent partial disability income payments under O.C.G.A. §34-9-263 and §34-9-264. This includes payment made in a lump sum for permanent partial disability.

d. Death income benefits under O.C.G.A. §34-9-265. This includes payment made in a lump sum. Payment made to the State Board of Workers' Compensation in death cases where there are no dependents must be shown in this section. Burial expenses must be shown in Section C (11) Burial Payments.

e. Stipulated settlements and amounts paid for no liability stipulated settlements should also be included in this section.

f. Advances.

6. Reimbursement of income benefits made by the Subsequent Injury Trust Fund MUST be included in amounts shown in payment type, and omitted in amounts shown in payments.

7. When salary is paid in lieu of income benefits, the period for which payments would have been made and the amount of income benefits that would have been paid must be shown.

8. Section C Payments must show all payments as of the date the report is filed less reimbursements made by the Subsequent Injury Trust Fund.

   a. Total Weekly Benefits. The amount shown must be the total of all payments shown in payment type, less reimbursements made by the Subsequent Injury Trust Fund.

   b. Physician Benefits. Show all payments made directly to a physician or medical group (not a hospital or hospital clinic).

   c. Hospital Benefits. Show all payments made to hospitals; include emergency room, outpatient care, inpatient care, and all other services provided by hospitals.

   d. Pharmacy Benefits. Show all payments to pharmacies, including reimbursements for drugs and non-prescription items.

   e. Physical Therapy. Show all payments for physical therapy, including education and patient care (not hospital or hospital clinic).

   f. Chiropractic. Show all payments to a doctor of chiropractic medicine or chiropractic clinic.

      THE COST OF MEDICAL CARE DOES NOT INCLUDE ANY AMOUNTS PAID FOR UTILIZATION OR BILL REVIEW

   g. Other (Medical). Show other related expenses which do not belong in another category. These include travel expenses (meals, lodging, mileage, etc.), home health care, nursing home care, home modification, and automobile or van modification.

h. Rehabilitation/Vocational (excluding all of the above). Show services for vocational rehabilitation suppliers and training expenses.

i. Late Payment Penalties. Show payment of all 15% and 20% late payment penalties provided for in O.C.G.A. §34-9-221(e) and (f).

j. Assessed Attorney's Fees. Show attorney's fees assessed as a penalty pursuant to O.C.G.A. §34-9-108(b). Do not show normal payment of attorney fees which are part of the employee's benefit or part of a settlement. **Do not show payments made to the attorney for the employer/insurer.**

k. Burial. Show burial expenses when paid. Maximum is $7,500.

9. Section D Recovery Code is where the amounts that were reimbursed by Subsequent Injury Trust Fund (indemnity and medical), Subrogation, Overpayment or Other reimbursement should be shown here on the WC-4.

10. Section E is checked to certify that the total payments are as correct as the available information indicates on the WC-4.

11. Provide the name and address of the insurer or self-insurer. If the insurer is part of a group that is using preprinted forms for more than one company, the name of the company insuring the loss should be indicated and the name and address of the claims office.

12. Type or print the adjustor's name and address of the claims office in the space provided. Include the phone number and e-mail address of the person (adjuster) authorized to answer any questions regarding the information contained in the Form WC-4.

13. File with the Board at required intervals.

References: O.C.G.A. §34-9-261
§34-9-262
§34-9-264
§34-9-265

Board Rule 61(b) (5)

Chapter 5

Electronic Date Interchange Fillings (EDI)

The Board is using Release 3 of the IAIABC's Electronic Data Interchange (EDI) standards the method to enter First Reports of Injury (FROI's) as well as Subsequent Reports of Injury (SROI's). The FROI's include data from the WC-1 forms while the SROI'S included data from WC-2, WC-2a, WC-3 and WC-4 forms. Insurers, self-insurers and group self-insurers, designated claims offices (TPA) can either file EDI through their own system or through and EDI vendor. Prior to filing EDI, you must file a Trading Partner Agreement with the Board.

A. Filing with the Board-EDI

1. Prior to filing in EDI, insurers, self-insurers, group self-insurers and designated claims office (TPAs) shall be certified to file via EDI by the Board.

2. Insurers, self-insurers, group self-insurers, designated claims offices (TPAs) or their designated vendors shall file Forms WC-1, WC-2, WC-2a, WC-3 and WC-4 via EDI in form of FROI's (First Report of Injury) and SROIs (Subsequent Report of Injury).

3. Insurers, self-insurers, group self-insurers, and designated claims offices (TPAs) shall not file any document or submit any transmission via EDI in any claim created prior to July 1, 2009. For any claim created prior to July 1, 2009, insurers, self-insurers, group self-insurers or designated claims offices (TPAs) shall file documents in paper unless and until web filing is available.

4. Any Form WC-1, WC-2, WC-2a, WC-3, or WC-4 that is filed in paper by an insurer, self-insurer, group self-insurer, or designated claims offices (TPA) concerning any claim created on or after July 1, 2009 may be rejected by the Board.

5. When filing via EDI, and whenever an attachment to a filing or submission is required, the employer, insurer, self-insurer, group self-insurer or designated claims office (TPA) shall simultaneously mail to, or electronically file with, the Board the filed Subsequent Report of Injury (SROI) or form and a copy of such attachment.

6. Pursuant to Board Rule 60(c), all attachments filed with the Board shall contain the employee's name, date of injury, and Board claim number. Any attachment that does not contain this information shall be rejected by the Board. Copies of all filings shall be served on the employee and the employee's attorney, if represented.

B. Compliance

If any insurer, self-insurer, group self-insurer, designated claims office (TPA, or their designated vendor submits transmission/documents successfully below 80%, the Board may suspend or terminated EDI filing privileges of insurer, self-insurer, group self-insurer, designated claims office (TPA) or their designated vendor unless or until such time as compliance is above 80% or otherwise deemed reasonable or appropriate by the Board.

Chapter 6

LUMP SUM AND ADVANCE PAYMENTS

A. Definition

O.C.G.A. §34-9-222(a) defines a lump sum payment as "…payment of a lump sum equal to the sum of all future payments, reduced to their present value upon the basis of interest calculated at 7 percent per annum."

O.C.G.A. §34-9-222(b), defines advance payments as "a part of the future income benefits…" In addition, "The repayment of partial lump sum advance payments, together with interest of 7 percent per annum, may be accomplished by reducing the period of payent or reducing the weekly benefit, or both, as may be directed by the board."

B. Application Procedure

Pursuant to Board Rule 222(a), the Board will consider an application for either a lump sum payment of all remaining income benefits or an advance of a portion of the remaining income benefits, but it will not consider any application unless benefits have been continued for at least 26 weeks. The employer/insurer may make a lump sum or advance payment without commutation of interest and without an award from the Board.

In lieu of a hearing, the Board will consider applications for advances and lump sum payments in accordance with the following procedure:

1. A request for an advance or lump sum payment must be submitted on Form WC-25, and a copy must be sent to the employer/insurer and any other interested parties. The applicant must complete the affidavit on the back of Form WC-25 and provide the following information:

    a. The current and past due living expenses, including rent, groceries, utilities, etc., as listed on the Form WC-25.

    b. A list of long-term debts, including loans for furniture, automobile, etc. Include for each total due, the date the debt was incurred, to whom the debt is owed, the amount of monthly payments, and purpose of the loan if it is not readily apparent from the name of the loan.

    c. The total income of the household from all sources.

    d. The needs required to be met to prevent extreme hardship or that are essential to the rehabilitation of the claimant.

    e. A list of the total number of children and their ages.

f. If represented, the fee of the attorney for obtaining the lump sum or advance payment.

g. If the request is for an advance, a proposed method of repayment must be included on Form WC-25.

2. A medical report no older than 60 days showing the physical status of the employee including the extent and duration of disability, and permanent partial disability rating, if any, must be attached to the Form WC-25.

3. Copies of contracts that show long-term debts must be attached or the request will be denied. Documentation for all past due bills must also be attached to the Form WC-25.

4. The Certificate of Service statement on the back of Form WC-25 must be completed with the date the document is mailed or delivered. The parties have 15 days from the date of the Certificate of Service to file objections to the application (the 15 day period begins with the date the Certificate of Service document is mailed or delivered). Objections to an application must be accompanied by documents in support of the objections, may be accompanied by counter-affidavits, and must be served upon the party or the attorney making the application.

5. If any party elects to cross examine an adverse party, it must notify the Board within 15 days of the date of the Certificate of Service on the Form WC-25 of its intention to submit a deposition. The deposition must be filed with the Board no later than 30 days from the Certificate of Service on the Form WC-25, unless the Board upon a showing of just cause grants an extension.

6. If, in the judgment of the Board, there are material and bona fide disputes of fact, the Board may schedule a hearing or assign the case to an Administrative Law Judge for the purpose of receiving evidence or schedule a mediation conference on the issues.

References: O.C.G.A. §34-9-222(a) (b)

Board Rules 61(b) (15), 222

Chapter 7

MEDICAL BENEFITS

A. Authorized Treatment

l. Method of Providing Medical Treatment

The employer may satisfy the requirements for furnishing medical care in one of the following manners:

a. The employer shall maintain a list of at least six non-associated physicians or professional associations or corporations of physicians who are reasonably accessible to employees. This list shall be known as the "Panel of Physicians." At least one of the physicians must practice the specialty of orthopedic surgery. Not more than two physicians on the panel shall be from industrial clinics. One physician on the panel must be a minority. The employee may make one change from one physician to another on the same panel without prior authorization from the Board.

However, the Board may grant exceptions to the required size of the panel where it is demonstrated that more than six physicians or groups of physicians are not reasonably accessible. In the event that the Board has granted an exception to any panel requirements, the exception must be posted in the same location as the panel.

b. The employer may maintain a list of a minimum of 10 physicians or professional associations reasonably accessible to the employees and providing the same types of healthcare services specified in Board Rule 201(a)(1) and the following healthcare services: general surgeons and chiropractors. This list shall be known as the "Conformed Panel of Physicians."

c. An employer or the workers' compensation insurer of an employer may contract with a workers' compensation managed care organization certified by the Board. Medical services provided in this manner shall be known as "Managed Care Organization Procedures." Employees shall be given notice of the managed care organization's network of eligible medical service providers and information regarding the contract and manner of receiving medical services, including a toll free 24-hour telephone number that informs employees of available services.

d. An employee may obtain the services of any physician from the panel and may thereafter elect to change to another physician on the panel without prior authorization from the Board. The physician so selected will become the primary treating physician in control of the employee's medical care.

If the panel of physicians is not posted or properly utilized, the employee may see the physician of his or her choice at the expense of the insurer/self-insurer. (See Section A-2 below).

The term, "physician," shall include any person licensed to practice a healing art and any remedial treatment and care in the State of Georgia.

"Minority" shall be defined as a group which has been subjected to prejudice based on race, color, sex, handicap or national origin including, but not limited to, Black Americans, Hispanic Americans, Native Americans, or Asian Americans.

2. Other Authorized Physicians

A referral by an authorized treating physician for the specific purpose of consultation, evaluation, testing, or diagnosis in connection with treatment prescribed by the authorized treating physician does not constitute a change of physician or treatment and does not require an order from the Board. However, a referral physician shall not be permitted to arrange for additional referrals.

A referral by the authorized treating physician for the purpose of providing the employee with a specific treatment or a special medical service which is related to the employee's compensable condition does not constitute a change of physician or treatment and does not require an order from the Board.

If an employer, after becoming aware of an injury, fails to provide adequate treatment for the injury, the employee may seek treatment from the physician of his/her choice at the insurer/self-insurer's expense. A failure on the part of the employer to render appropriate assistance to the employee or explain the employee's rights in making a selection or arranging for treatment from a posted panel, conformed panel, or managed care organization, may constitute failure to furnish adequate treatment. Notwithstanding any selection made pursuant to his/her panel rights, an employee, after a compensable injury and within 120 days of receipt of any income benefits, shall have the right to one examination at a reasonable time and place, within this state or within 50 miles of the employee's residence, by a duly qualified physician or surgeon designated by the employee and to be paid for by the employer/insurer. Such examination shall not repeat any diagnostic procedures which have been performed since the date of the employee's injury unless the costs of such diagnostic procedures which are in excess of $250 are paid for by a party other than the insurer/self-insurer.

If an emergency situation arises in which there is not time to comply with selection requirements, the injured employee is authorized to seek treatment from a physician of his/her choice; this authorization lasts for the duration of the emergency. An emergency may be defined as "an unforeseen occurrence or combination of circumstances which calls for immediate action or remedy; pressing necessity; exigency." All follow-up medical care should be supplied by a physician from the panel, conformed panel (or the authorized treating physician's referral), or from the managed care organization's provider network.

3. Change of Physicians/Treatment

   Upon the request of an employee, employer, or insurer/self-insurer, or upon its own motion, the Board may, after notice is given in writing of the request to all interested parties and allowing any interested party 15 days from the date of notice to file written objections to the request, order a change of physician or treatment.

   A request for, or objection to request for a change of physician or additional treatment must be filed on a Form WC-200b, with supporting documentation attached, and copies must be provided to all parties or their attorneys. In cases that have been designated as "Medical Only", the requesting party must file a Form WC-14 Notice of Claim or a WC-1 along with the Form WC-200b. Parties are required to make a good-faith effort to reach a resolution of this issue prior to filing a request with the Board. A mediation conference may be scheduled upon receipt of the request by the Board.

   Factors which may be considered in support of the request or objection may include, but are not limited to, the following:

   a. Proximity of physician's office to employee's residence
   b. Accessibility of physician to employee
   c. Excessive/redundant performance of medical procedures
   d. Necessity for specialized medical care
   e. Language barrier
   f. Referral by authorized physician
   g. Noncompliance of physician with Board rules and procedures
   h. Panel of physicians
   i. Duration of treatment without appreciable improvement
   j. Number of prior treating physicians
   k. Prior requests for change of physician/treatment
   l. Employee released to normal duty work by current authorized treating physician
   m. Current physician indicates nothing more to offer

   If the argument in support of, or objection to, the change is based on testimony, an affidavit must be attached to the form and, if the argument refers to documents, a copy of the documents must be attached.

B. Independent Medical Examination and Evaluation

1. The insurer/self-insurer has the right to request that the injured employee submit to an independent medical examination, which shall include physical, psychiatric, and psychological examinations. An examination may include reasonable and necessary testing, including functional capacity evaluations, as recommended by the examining physician.

2. The insurer/self-insurer shall notify the employee in writing at least 10 days in advance of the time and place of the requested examination. Advance payment of travel expenses as required by Rule 203 (d) (3) shall accompany the notice.

3. The insurer/self-insurer cannot unilaterally suspend income benefits for failure of the employee to attend the scheduled examination. If the injured employee fails to cooperate with the insurer/self-insurer's efforts to schedule an independent medical examination, the insurer/self-insurer may request an order suspending the employee's benefits by filing a motion to suspend on Form WC-102D and attaching appropriate documentation in support of the motion.

4. The employee has a right to an independent medical examination by a physician designated by the employee within 120 days of receipt of income benefits when the requirements of O.C.G.A. § 34-9-202(e) are met.

C. Payment of Medical Expenses (Board Rule 203(a))

The insurer/self-insurer are responsible for the payment of all reasonable, necessary, and related medical expenses prescribed by an authorized treating physician, including diagnostic testing, to determine causation. The insurer/self-insurer may automatically conform charges according to the fee schedule adopted by the Board and shall pay within 30 days from the date of receipt of the charges. Within 30 days of the receipt of medical charges, the insurer/self-insurer must provide written notification to the medical provider of the reasons for non-payment of the expenses and a written itemization of any documents or other information needed to process the claim for medical benefits. The insurer/self-insurer must notify the medical provider in writing within 30 days of the receipt of the charges of the need for further documentation. Failure to do so will be deemed a waiver of the right to defend a claim for failure to pay charges in a timely fashion on the ground that the charges were not accompanied with the proper documentation. However, this waiver does not extend to any other defense the insurer/self-insurer may have with respect to a claim of untimely payment. If the insurer/self-insurer is controverting the medical expenses, they must file a Form WC-3, Notice of Controvert, with the Board within the 30 days allowed for payment. All persons having a financial interest, including the physician, must receive a copy of the Form WC-3.

Medical expenses shall include, but are not limited to, the reasonable cost of travel between the employee's home and the place of examination or treatment, including physical therapy appointments or pharmacy visits. When travel is by private vehicle, the rate of mileage shall be 40 cents per mile. Travel expenses beyond the employee's home city shall include the actual cost of meals and lodging. Travel expenses shall further include the actual reasonable cost of meals when total elapsed time of the trip to obtain outpatient treatment exceeds four hours per visit. Cost of meals shall not exceed $30 per day. Medical expenses include the reasonable cost of attendant care directed by the treating physician during travel and convalescence.

Reasonable medical charges must be paid within 30 days of the date that the insurer/self-insurer receives the charges and reports. If the medical charges are not paid within 30 days of the receipt of the documentation required by the Board, the following penalties will apply automatically: A 10% penalty on reasonable medical charges paid after 30 days but before 60 days; a 20% penalty on reasonable medical charges paid after 60 days but before 90 days; and, in addition to the 20% penalty, a 12% per annum interest rate is charged on reasonable medical charges paid after 90 days. The penalties and interest are payable directly to the provider.

D. Procedure When Amount of Medical Expenses, Necessity of Treatment or Authorized Treatment are Disputed (Board Rules 203(b), 205)

Medical expenses shall be limited to the usual, customary and reasonable charges. Employers/insurers may automatically conform charges according to the fee schedule adopted by the Board, and the charges listed in the fee schedule shall be presumed usual, customary and reasonable and shall be paid within 30 days from the date of receipt of the charges. Employer/insurers shall not unilaterally change any CPT-4 code of the provider. All charges that are automatically conformed according to the fee schedule adopted by the Board shall be for the CPT-4 code listed by the provider. In situations where charges have been reduced or payment of a bill denied, the insurer, self-insurer, or third party administrator shall provide an Explanation of Benefits with payment information explaining why the charge has been reduced or disallowed, along with a narrative explanation of each Explanation of Benefits code used.

Any health service provider whose fee is reduced to conform to the fee schedule may request peer review of charges and present evidence as to the reasonableness of his/her charges. If the dispute is not resolved through the recommendations of peer review then a mediation or hearing may be requested. An employer/insurer who disputes that any charge is the usual, customary and reasonable charge prevailing in the State of Georgia shall, within 30 days of the receipt of the charges, file with the appropriate peer review committee a request for review of only those specific charges which are disputed. No CPT, DRG, or ICD-9 Codes are to be changed without first notifying, and then obtaining permission from, the authorized treating physician/hospital. Any physician/hospital whose charges are disputed and any party disputing such charges must comply with requirements of law, Board rules, and, if applicable, rules of the appropriate peer review committee before the Board will order payment of any disputed charges. The injured worker's name and address must be included in the request for peer review. Effective July 1, 1992, Board Rule 203(b) was changed to allow all parties to correspond directly with Board approved peer review committees. These committees may be contacted at the following addresses.

Dr. Mitchell S. Nudelman (effective until December 1, 2010)
Medical Director Solutions, LLC
577 Seminole Drive
Marietta, GA 30060
(770) 499-0398 FAX (770) 499-8299

Dr. Michael Walsh, Executive Director
Georgia Chiropractic Association, Inc.
1926 Northlake Parkway, Suite 201
Atlanta, GA 30084
(770) 723-1100 FAX (770) 723-1722

Mr. Clark Thomas, Executive Director
Georgia Psychological Association
2200 Century Pkwy, NE, Suite 660
Atlanta, GA 30345
(404) 634-6272 FAX (404) 634-8230

Mr. Stuart Platt, M.S.P.T., P.T., Principal
Appropriate Utilization Group, LLC
881 Piedmont Avenue
Atlanta, GA 30309
(404) 728-1974

Within 30 days of the date that a decision is issued by a peer review organization, the employer/insurer shall either make payment of disputed charges based upon the recommendations of the peer review committee or request mediation. If the dispute is not resolved through mediation, a hearing may be requested. The peer review committee shall serve a copy of its decision upon the employee, or represented by counsel, on the employee's attorney. A physician whose fee has been reduced by the peer review committee shall have 30 days from the date that the recommendation is mailed to request mediation. If the dispute is not resolved through mediation, a hearing may be requested. In the event of a hearing, the recommendations of the peer review committee shall be prima facie proof of the usual, customary and reasonable charges.

E. Medical Reports

Medical reports shall not be filed with the Board, unless specifically required by a Board rule or otherwise requested by the Board. Do not file miscellaneous medical statements and bills covering items such as drugs, ambulance service, and prosthetics. When required by Board Rule 61(b) (12), (15), and (16) or Board Rule 200(c), all medical reports must be filed with the Board within 10 days of the insurer/self-insurer's receipt of same. If a physician attaches a narrative report to a form instead of completing the form, the insurer/self-insurer should complete the employee information and send both to the Board, making certain the narrative report is securely attached to the form. The insurer/self-insurer should, however, encourage physicians to complete the forms. The insurer/self-insurer should always verify the name and address of the employee and the employer, employee's social security number, and the injury date to make certain the information corresponds to that given on the Form WC-1. Do not file miscellaneous medical statements and bills covering items such as drugs, ambulance service, and prosthetics.

Form WC-20(a) - Medical Report
(May also file HCFA 1500 or UB 04)

The attending physician or other practitioner completes the report to document treatment and forwards it along with office notes and other narratives to the insurer/self-insurer as follows:

1. Within seven days of initial treatment;

2. Upon the employee's discharge by the attending physician or at least every three months until the employee is discharged;

3. Upon the employee's release to return to work; and

4. When a permanent partial disability rating is determined.

The insurer/self-insurer shall file the report including office notes and narratives with the Board as follows:

1. When the report contains a permanent partial disability rating;

2. Upon request of the Board;

3. To comply with other rules and regulations of the Board; and

4. In conjunction with the filing of a Rehabilitation Plan with the Board.

The employer/insurer shall maintain copies of all medical reports and attachments in their files and shall not file medical reports except in compliance with Board Rule 61(b) (12), (15), and (16) and Rule 200(c).

F. Pre-Authorization of Medical Treatment

Although pre-authorization of medical treatment is not required in worker's compensation claims, an authorized medical provider may request advance authorization for treatment or testing by utilizing Board Form WC-205 and faxing or e-mailing this form to the insurer/self-insurer. The insurer/self-insurer must respond within five (5) business days of receipt of the form by completing Section 3 of the Form WC-205 and faxing or e-mailing to the authorized medical provider. If the insurer/self-insurer fails to respond to the WC-205 request within 5 days, the treatment or testing stands pre-approved.

In the event the insurer/self-insurer furnish an initial written refusal to authorize the requested treatment or testing within the five business day period, then within 21 days of the initial receipt of the WC-205, the insurer/self-insurer shall either: (a) authorize said requested treatment or testing in writing; or (b) file with the Board a Form WC-3 controverting the treatment or testing indicating the specific grounds for the controvert.

G. Reimbursement of Group Carrier or Other Healthcare Provider

Form WC-206, including supporting documentation, shall be submitted to the Board during the pendency of the claim by the party seeking reimbursement for costs of medical treatment. The party requesting reimbursement must send a copy of the WC-206 to all parties, their counsel, and parties at interest. When the Board receives a request for reimbursement and designation as a party at interest, the Board will provide the party at interest with notice of the hearing.

References: O.C.G.A. §34-9-200
§34-9-201
§34-9-202
§34-9-203
§34-9-205
§34-9-206

Board Rules 61, 200, 201, 202, 203, 205, 206

Chapter 8

REHABILITATION & MANAGED CARE

This chapter of the Procedure Manual has been made into a separate manual; Rehabilitation & Managed Care Procedure Manual. The most recent version is available at the Board's website, www.sbwc.georgia.gov, under Publications.

Chapter 9

GEORGIA SUBSEQUENT INJURY TRUST FUND

A. Legislative Intent

Effective July 1, 1977 the Georgia Legislature amended the Georgia Workers' Compensation Law by creating a Subsequent Injury Trust Fund and enacted the following statement of legislative intent:

> "It is the purpose of this Chapter to encourage the employment of persons with disabilities by protecting employers from excess liability for compensation when an injury to a disabled worker merges with a pre-existing permanent impairment to cause a greater disability than would have resulted from the subsequent injury alone."

B. Administration of the Fund

The Subsequent Injury Trust Fund was established as a separate agency independent from any other department. The Fund is governed by a five-member Board appointed by the Governor for six-year terms. Board members represent management, labor, the insurance industry, rehabilitation professionals, and the public at large. In addition, ex-officio or advisory members are the Executive Director of the State Board of Workers' Compensation and the Georgia Insurance Commissioner. The Board of trustees appoints an administrator who is responsible for the day-to-day management and the administration of the fund.

C. Prerequisites for Reimbursement from the Fund

The employee must have a pre-existing permanent impairment.
The law defines “permanent impairment” as any permanent condition due to previous injury, disease or disorder, which is, or is likely to be, a hindrance or obstacle to employment or re-employment. In addition, the employer must have reached an informed conclusion prior to the occurrence of the new injury or occupational disease that the pre-existing impairment was permanent and likely to be a hindrance to employment or re-employment.

There must be a merger between the pre-existing impairment and the new injury. Merger is defined as follows:

1. Had the pre-existing permanent impairment not been present, the subsequent injury would not have occurred. (Example: A blind worker does not see a dangerous situation developing and consequently suffers injury by accident.)

2. The disability resulting from a new injury in conjunction with a pre-existing, permanent impairment is substantially greater than that which would have resulted had the pre-existing, permanent impairment not been present and the employer has been required to

pay and has paid compensation for that greater disability. (Example: An employee with a pre-existing heart condition who suffers a compensable heart attack because of aggravation of the pre-existing heart condition).

3. Death would not have been accelerated had the pre-existing, permanent impairment not been present.

D. Conditions Covered

As stated in paragraph C, a permanent impairment is any permanent condition due to a previous injury, disease, or disorder which is likely to be a hindrance or obstacle to employment. Furthermore, the law requires that the employer reach an informed conclusion that it considered the impairment permanent and likely to be a hindrance to employment. When the employer established knowledge (prior to the subsequent injury date) of any of the following conditions, there is a presumption by law that the employer considered the condition to be permanent and likely to be a hindrance to employment or re-employment:

1. Epilepsy
2. Diabetes
3. Arthritis which is an obstacle or hindrance to employment or re-employment
4. Amputated foot, leg, arm or hand
5. Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than 75% bilaterally
6. Cerebral palsy
7. Residual disability from poliomyelitis
8. Multiple sclerosis
9. Parkinson's disease
10. Cardiovascular disorders
11. Tuberculosis
12. Mental retardation provided the employee's intelligence quotient is such that he falls within the lowest two percentile of the general population. It shall not be necessary for the employer to know the employee's actual relative ranking in relation to the intelligence quotient of the general population
13. Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months
14. Hemophilia
15. Sickle cell anemia
16. Chronic osteomyelitis
17. Ankylosis of major weight bearing joints
18. Hyperinsulism
19. Muscular dystrophy
20. Total occupational loss of hearing as defined in Code Section 34-9-264
21. Compressed air sequelae
22. Ruptured intervertebral disc

23. Any permanent condition which, prior to the injury, constitutes a 20-percent impairment of a foot, leg, hand, or arm, or to the body as a whole

One of the questions most frequently asked by employers and insurers alike is: "What must an employer do to establish that it reached an informed conclusion that it considered the prior impairment likely to be a hindrance to employment?" There is obviously no one answer to this question because each employer looks at this situation differently. The following represents the fund's position: The employer must provide factual information verifying knowledge and supporting the conclusions that the pre-existing condition was permanent and a hindrance to employment. Several items may be available in a case to help establish the above. These are:

1. What the employee says;
2. Visible impairment (i.e. obvious impairment, a physical condition readily visible to the employer);
3. Job modifications;
4. What fellow employees say to employer;
5. Medical reports;
6. Employment applications;
7. Post offer-employment physical evaluations, questionnaires (if the employer is subject to the ADA);
8. Prior group insurance claim;
9. Prior workers' compensation claims.

The above represents several elements of factual information, which may support the employer's informed conclusion. It must be emphasized that the employer's knowledge and informed conclusion must take place prior to the subsequent injury, not necessarily prior to the date of hire or offer of employment. The insurer or physician's knowledge in absence of employer's knowledge is not sufficient.

NOTE: Submission of an employee's confidentially held medical records in employer's files to Industrial Commissions and Second (Subsequent) Injury Funds is authorized per the EEOC's assistance manual on the Americans with Disabilities Act.

E. Knowledge Affidavit

The employer is required to submit a notarized knowledge affidavit containing the information outlined in the example found in Rule 622-1-.05. This form is available on the fund's website www.sitf.georgia.gov. Submission of the knowledge affidavit to the fund is a prerequisite; however, this does not automatically entitle the employer or insurer to reimbursement. If the fund has any questions regarding the validity of information contained in the knowledge statement, the fund will either contact the employer or insurer for additional clarification or conduct an investigation on its own.

On many occasions, employer's knowledge affidavits are not consistent with other facts in the case. The claims person should review the employer's knowledge statement in light of other facts in the case as they pertain to the employee's prior impairment and injury.

Often the employer will refer to source documents such as employment applications, medical reports, pre-employment or post-employment offer reports and others as sources of information about the prior impairment. When this occurs, the employer must submit a copy of the referenced documents and certify that they were contained in the employer's files prior to the subsequent injury date. The fund's objective is to receive an affidavit from the employer that basically stands on its own merits.

Code Section 34-9-361 requires that the employer establish that it reached an informed conclusion that it considered the prior condition permanent and a hindrance to employment. The employer must reflect those facts or circumstances known to the employer that aided it in establishing the "informed conclusion" required under the law. The affidavit contents outline those circumstances.

Frequently, investigations reveal that the employer knows very little about the contents of the affidavit. Some employers have even indicated that the affidavit was pre-prepared with little or no discussion and submitted for signature. When this occurs, the chances of the fund denying the claim are greater. As a legal document the importance of the affidavit should be discussed with the employer. One should emphasize that the employer relay its true understanding and feelings about the employee's prior impairment. The affidavit should be prepared and signed by someone who is in a responsible position involved in the employment or employee retention process.

F. Filing of Claims

The law requires an employer or insurer to notify the administrator of the fund of any possible claim against the fund as soon as practicable, but in no event later than the payment of 78 weeks of income or death benefits, or within 78 calendar weeks from the date of injury, whichever occurs last. In addition, the employer's claim must be filed with the fund prior to the employee's final settlement of his/her claim.

The payment of 78 weeks of income or death benefits does not necessarily constitute a calendar period; 78 weeks of benefits could be paid over a longer period, or in a lump sum.

In accordance with OCGA 34-9-368 the Subsequent Injury Trust Fund will not accept claims for reimbursement that have an accident date of July 1, 2006 or later.

The employer/insurer must file the initial claim with the fund. Notification shall be in writing, transmitted on the facsimile machine, or transmitted electronically via the fund's website www.sitf.georgia.gov and shall be effective on the date of receipt of the notice by the fund. The notification must be filed on the Subsequent Injury Trust Fund's Form "A", which is referred to as Notice of Claim. In accordance with OCGA 34-9-362, an employer/insurer has

until June 30, 2009 to obtain a reimbursement agreement issued by Subsequent Injury Trust Fund for a Notice of Claim that was filed on or before July 1, 2006. Thereafter, an employer/insurer has 36 months, from the date of Notice of Claim is received by the Subsequent Injury Trust Fund, in which to obtain a reimbursement agreement issued by the Fund. The employer must provide the following information:

1. Employer's knowledge affidavit pursuant to Rule 622-1-.05 of the Subsequent Injury Trust Fund.

2. Documentation supporting merger between the subsequent injury and prior impairment. This is usually medical information or sufficient investigative materials to support merger dependent upon the type of merger claimed by the employer or insurer.

3. Proof of a compensable injury under Georgia Workers' Compensation laws.

4. When an employer's claim has been accepted for reimbursement, proof of payment of weekly income benefits to the injured worker in excess of 104 weeks or payments for medical and rehabilitation benefits in excess of $5,000.00 or proof that an award of such benefits has been issued.

Forms are available at the fund's website www.sitf.georgia.gov.

The documentation referred to in the above statements is generally developed in a manner concurrent with the development of the employer or insurer's file. The fund reviews each active claim and will request additional information, if necessary.

An employer should look for certain elements that will be helpful in determining when it should file a claim against the fund. Medical reports often reveal the existence of prior impairments or aggravations of pre-existing conditions by the subsequent injuries.

When the reserves of a case approach 104 weeks or $5,000 in medical expense, a claim should be filed. If a lump sum payment of 78 or more weeks or medical expense in excess of $5,000 is anticipated, one should file before making such a payment.

G. Expenses Covered

When a case qualifies for reimbursement from the fund, the employer is at all times required to pay all compensation benefits directly to the injured worker. If payment exceeds 104 weeks of income benefits, the fund will reimburse 100% of all income payments thereafter.

The employer is responsible for the first $5,000 in medical care and rehabilitation services. The fund will reimburse 50% of all medical and rehabilitation expenses, which exceed $5,000 but do not exceed $10,000. After medical and rehabilitation expenses exceed $10,000 the fund will reimburse 100% of all medical and rehabilitation expenses. Reimbursement requests should be made as soon as the employer or insurer has received the Workers' Compensation

Board approved Reimbursement Agreement, and every 13 weeks thereafter. Reimbursement checks are usually issued bi-monthly.

Medical and compensation payments are handled separately by the fund. In other words, medical and rehabilitation expenses can be reimbursed even though the employer may not have paid 104 weeks of weekly income benefit payments. It should be emphasized that the 104 weeks is not a calendar waiting period before the fund begins reimbursement. The employer or insurer must have actually paid out the equivalent of 104 weeks of compensation payments.

If the employer or insurer settles the case by stipulation, the statutory deductibles (104 weeks of income benefits) will be subtracted from the weekly benefits and/or total settlement paid in order to compute reimbursement. In computing reimbursement, consideration will be given to that portion of the settlement, which applies toward future medical payments. The fund will take into consideration the medical evidence regarding the likelihood of future medical expenses in computing reimbursement on settled cases.

In all instances, the employer must incur liability above the thresholds in order for the fund to begin reimbursing. This standard applies regardless of whether a case is paid on a weekly basis or lump sum settlement.

The disposition of a case through the use of a “no liability” stipulation precludes fund recovery.

If an employee suffers an injury which entitles an employer/insurer to reimbursement from the fund and then returns to work for the same employer without break in service and suffers another injury which merges with the same condition on which the prior claim was accepted by the fund, a second deductible or threshold does not apply to the last injury period, even if the employer changed insurance carriers. The employer/insurer will only be required to complete the remaining deductible, if any, from the previously reimbursable injury.

H. Reimbursement Agreement

Rule 622-1-.06(1) requires that the employer/insurer and the fund reach an agreement setting forth factual information establishing the employer's right to reimbursement. This reimbursement agreement is initiated by the fund and forwarded to the employer or insurer for signature. This agreement must be approved by the State Board of Workers' Compensation.

When the fund accepts reimbursement liability, the employer/insurer must immediately lower the reserves on the case to the limit of employer's liability (104 weeks of income benefits and not more than $7,500 in medical/rehabilitation payments). Under these circumstances, the reserves normally over these limits will not enter the experience factor of computing the employer's premiums.

I. Reimbursement Request

The fund will require the employer to submit an itemized statement of weekly income benefits paid to the injured employee. In addition, an itemized statement of medical benefits paid on behalf of the employee must be submitted to the Subsequent Injury Trust Fund along with providers' charges or a fee schedule audit. An employer or insurer, who can provide a certified counterpart of its electronically-generated or computer-generated pay document which identifies payment date, provider name, provider service, treatment (CPT) codes, and the amount paid, may be relieved from the requirement of providing the Subsequent Injury Trust Fund with copies of providers' charges. The Subsequent Injury Trust Fund may require narrative reports when deemed reasonably necessary.

Weekly income and medical and rehabilitation benefit reimbursement requests are outlined in Subsequent Injury Trust Fund Form C, "Reimbursement Request". No reimbursement will be made unless a reimbursement request form is completed and signed by the claiming party. This form may be downloaded from the fund's web site www.sitf.georgia.gov.

Rule 662-1-.06 requires that the employer or insurer attest to its efforts to assure that the injured employee is entitled to receive, or continue to receive, workers' compensation benefits. Failure to comply with this regulation may subject a claim to a denial of reimbursement benefits. By the time a case reaches the point where it is accepted by the fund, the necessary information attesting to the employer's efforts to assure that the injured employee is entitled to receive benefits should be in the fund's file. This is a continuous requirement, and even though a case is accepted, the fund must have the assurance of the employer or insurer that the injured employee continues to be entitled to receive compensation.

In completing a reimbursement request, the insurer must show in the appropriate section the total income benefits paid from the day of disability through the date of the request. This includes all payments for total disability, including salary paid in lieu of compensation, temporary partial and permanent partial disability.

In addition, there are categories for other payments. "Other" generally refers to death benefits, stipulated settlements or lump sum advances. The total compensation payment is inserted in the line or space entitled "Total Indemnity to Date."
From the total amount of indemnity paid, subtract benefits paid for 104 weeks (deductible.) If the 104 weeks includes temporary partial disability payments, the payments must be shown separate from the total disability weeks and the employer must provide the fund with a weekly accounting for wage loss (temporary partial benefits) paid to the employee. On the reimbursement request form, there is a section shown as: "Less 104 Weeks Consisting of". The purpose of this section is to itemize the total number of weeks paid in total disability benefits and the total in temporary partial disability benefits. The sum of these two amounts will be subtracted from the total indemnity paid to date. This will yield the net reimbursable indemnity. In the space below, insert the amount of previous indemnity reimbursement by the fund. Subtract this from the net reimbursable indemnity to arrive at the total indemnity amount requested.

In outlining the medical and rehabilitation expenses on a case, follow the instructions on the reverse side of the reimbursement request form. For costs incurred after January 1, 1991 the fund must be furnished with corresponding medical narratives and rehabilitation reports before reimbursement for such expenses can be considered. For reimbursement requests received after April 7, 2002, an employer's insurer who provides its electronically generated pay document which identifies payment date, provider service, treatment (CPT) codes, and the amount paid may be relieved from providing copies of providers' charges (bills). This provision generally pertains to routine or repetitive treatments; however, the Subsequent Injury Trust Fund may require submittal of narrative reports when it deems it to be reasonably necessary.

If the claims person has any questions about these instructions, a phone call to the fund for clarification is suggested. Any error in the preparation or outlining of the medical bills may result in the reimbursement request processing being delayed or returned. Rule 622-1-.06(1) was amended June 18, 1998, July 11, 2000, April 7, 2002 and again December 31, 2002 allowing for further reduction in paperwork and fund reimbursement of Medicare set-aside trusts.

J. Management of Employee's Claims

The employer or insurer handles the employee's claim throughout the life of the claim. This is true even though the fund has accepted reimbursement responsibility. The employer's or insurer's failure to perform in this capacity may subject the reimbursement claim to denial or suspension of reimbursement. The fund does not have the staffing to handle or manage the employee's claim. In accordance with fund rules, the employer or insurer is required to keep the fund informed about case developments as they occur. The employer/insurer should keep the fund advised on matters such as litigation, appeals and settlements.

The fund will not accept an employer/insurer's attempt to transfer claim management responsibility to the fund after reimbursement has been accepted. The employer/insurer is expected to handle the employee's claim as though the fund were not involved. The employer/insurer should provide benefits consistent with the employee's injury and entitlement according to law.

K. Rehabilitation

The purpose of the Subsequent Injury Trust Fund is to serve as a tool to assist in the rehabilitation process by offering an additional incentive to employers in employing workers with disabilities. Therefore, the fund will not disregard the employer's responsibility to provide effective rehabilitation to the injured worker in those cases where the law does not make rehabilitation services optional.

L. Denied Subsequent Injury Fund Claims

Rule 622-1-.06(2) states that in the event the insurer/self-insurer and the fund fail to reach an agreement, the claiming party may make an application to the State Board of Workers' Compensation for a hearing in regard to the matters at issue through the use of Form WC-14, Notice of Claim/Request for Hearing. This application for hearing must be submitted to the State Board of Workers' Compensation within 90 days of the fund's denial of a claim with a copy forwarded to the fund. The employer may move for reconsideration by submitting to the fund administrator additional information the employer feels may reverse the fund's denial. This additional information should be in the fund's hands no later than 15 days prior to the initially scheduled hearing date. If the parties cannot reach an agreement, either party may request a mediation conference before the State Board of Workers' Compensation. These provisions, however, do not enlarge the (90 day) time period in which the employer or insurer must file a form WC-14 with the State Board of Workers' Compensation challenging the fund's denial.

The employer/insurer should not request a hearing on a claim against the Subsequent Injury Trust Fund until the issue of compensability of the employee's claim is resolved.

M. Settlements Subsequent to Reimbursement Agreements

Pursuant to Code Section 34-9-363.1 and Rule 622-1-.07, an employer or insurer must obtain approval from the fund prior to settling the employee's claim on those cases where a Reimbursement Agreement exists, or the State Board of Workers' Compensation ordered reimbursement.

The employee or his/her attorney should submit a written demand to the employer/insurer and forward a copy to the fund. This copy serves as an advance notice that a settlement authority request from the employer/insurer may be forthcoming; however, the fund cannot begin its evaluation until it receives a formal request from the employer or insurer, along with the employer/insurer's evaluation, recommendations and rationale. Oftentimes delays are encountered when the fund has not been provided with the most current medical and rehabilitation narratives.

The Subsequent Injury Trust Fund authorizes the amount of the settlement it will reimburse the insurer. It will not go above the insurer’s recommended amount. The Subsequent Injury Trust Fund does not negotiate settlements with the injured workers or their legal representatives. The insurer should make its settlement authority request to the Subsequent Injury Trust Fund, and commence negotiations within the Fund’s authority in an expeditious manner.

The newly implemented 1 to 3 year “settlement” reimbursement program will allow settlement of more cases during these three years. The Fund has instituted the structured reimbursement process as follows: Any settlement up to $75,000.00 will be reimbursed in full as the current backlog allows.

Any settlement of a case from $75,000.00 to $150,000.00 will be paid under an installment process of $75,000.00 within the seven to eight months (depending on the backlog). The remaining installment will be reimbursed on the payment anniversary date twelve (12) months later. Even though the insurer and self-insurer will be receiving reimbursements in installments, the Fund will not require additional filing seeking reimbursement of settlement funds, but rather the Fund will automatically issue a settlement reimbursement payment on the anniversary date of the initial installment payment.

Any settlements of $150,000.00 to $225,000.00 will be paid at $75,000.00 per twelve (12) month period with the second and third payments being automatically issued on the anniversary date of the prior payment. Any settlements above $250,000.00 will be reimbursed in three (3) yearly equal installments. Again, the subsequent installment payments will automatically be issued by the Fund, and the insurer and self-insurer can calendar the anticipated date of payment so that budgeting and other fiscal planning can be made by the insurers and self-insurers. The Fund's goal is not to impair the settlement process but to create a system wherein settlements can continue.

When a party requests a settlement mediation conference to be scheduled by the State Board of Workers' Compensation on an accepted fund claim, the fund should also receive a copy of that request from that party (or Form WC-100). This allows the fund to be on advance notice for an earlier evaluation assignment to fund staff.

When the State Board of Workers' Compensation approves a stipulated settlement on a fund-accepted claim and the fund has not granted settlement authority, the reimbursement agreement between the employer/insurer and the fund shall become null and void. The State Board of Workers' Compensation shall, upon petition of the administrator of the fund, issue an order rescinding the reimbursement agreement and may order an employer or insurer to repay the fund any monies the fund previously reimbursed on that case.

N. General Remarks

In most cases, the fund's file is not developed until a substantial period of time has elapsed from the date of injury. Once a claim has been received by the fund, it must then develop the file by reconstructing events that have taken place. The fund may ask the employer/insurer to supply:

1. Employer's First Report of Injury or Occupational Disease (Form WC-1)
2. Copies of pertinent orders, completed Workers' Compensation Board forms or awards from the Board, including Stipulation and Agreements (settlements)
3. Medical reports pertaining to the prior impairment
4. Medical reports pertaining to the subsequent injury
5. Employer's Knowledge affidavit

6. Any additional supporting documents that accompany the knowledge affidavit along with employer's letter certifying that documents were contained in employer's files prior to the subsequent injury date.
7. Rehabilitation reports

In most instances, the resolution of a claim against the fund will depend upon medical questions that deal with the element of merger. This is why the fund frequently requests copies of the hospital admission, operative and discharge summaries. Furthermore, it may request copies of medical reports or information pertaining to the prior impairment to determine whether or not the prior impairment was the principal factor that materially, substantially and cumulatively aggravated the subsequent injury so as to synergize a greater degree of disability when considered together; and whether or not the employer has been required to pay for that greater disability. O.C.G.A. §34-9-351. SITF v. Harbin Homes, 182 Ga. App. 316, 318 (355 SE2d702)(1987).

References: O.C.G.A. §34-9-351
§34-9-360
§34-9-361
§34-9-362
§34-9-363.1
§34-9-368

SITF Rules 622-1-.04, 622-1-.05, 622-1-.06, 622-1-.07

Chapter 10

CERTIFIED WORKERS' COMPENSATION PROFESSIONAL CERTIFICATION PROGRAM

CERTIFICATION PROCEDURE

A. Purpose And Applicability

To promote professionalism in the industry and improve the handling and continuity of workers' compensation claims, the State Board of Workers' Compensation has created a certification program so that a person involved in any aspect of workers' compensation claims can become a Certified Workers' Compensation Professional (CWCP). This procedure establishes the framework for acquiring and maintaining the certification as a CWCP, including application, training materials, testing, certifying and continuing education. This procedure reflects the desire of the Board to proactively implement a mechanism to create a more uniform standard of knowledge among persons working in the Workers' Compensation field, thus benefiting the entire process of administering Workers' Compensation claims.

B. Certification Optional

Certification as a CWCP is voluntary. It is in no way mandatory for persons working in the Workers' Compensation field in the State of Georgia

C. Definitions

Unless the context otherwise requires, the terms found in this Certification Procedure are used as defined in §O.C.G.A. 34-9-1. Other terminology is used in accordance with the Georgia Workers' Compensation Code, or industry usage, if not defined in the Georgia Workers' Compensation Code.

CWCP – Certified Workers' Compensation Professional

Administrator - the administrator of the Certification Program under purview of the Licensure Division of the State Board of Workers' Compensation and the Certification Committee.

Certification Committee - the committee appointed by the Chair of the Licensure and Self-Insurance Committee of The Chairman's Advisory Council to administer the certification of CWCP course sponsors and oversee the administration of the CWCP course. The committee shall consist of five (5) members. Three (3) of the members shall be appointed from the Licensure and Self-Insurance Committee of the SBWC Advisory Council. Two (2) of the members shall be Board personnel.

D. Filing Of Forms

1. Unless otherwise indicated and to the extent provided, each filing required under this Certification Procedure is to be made on forms specified by this procedure.

2. Forms may be reproduced and may be altered to accommodate manual or automated processing provided the same information is presented in the same order as in the forms herein promulgated.

3. Upon specific request by the person required to make such filing, the Certification Committee may, with the approval of the Administrator, approve a method of electronic filing.

E. Application For Certification

1. To be eligible for certification as a CWCP, an applicant must make proper application to an approved CWCP training program, and pay all required fees.

2. A person registered to take the CWCP course that has not completed the requirements for certification within one year after beginning the course must submit a new application to be considered for certification.

3. In lieu of E. 1. and 2. above, the applicant may present satisfactory evidence to the Certification Committee and the Administrator in the form of a college transcript from an accredited college or university of successful completion of ten (10) quarter hours (or the equivalent) of Workers' Compensation courses. These courses must include such topics as set out in Section B (c), of the Certification of CWCP Training Course Sponsors Section.

F. Examinations

1. All applicants for certification as CWCP are required to submit to an examination given by the course sponsor. The examination shall be given following the completion of required course work, at times determined by the course sponsor.

2. No person shall be eligible to take a CWCP examination unless that person has properly made application to take an approved CWCP course, paid the tuition fee, and completed the required course work.

3. The format of the test shall be approved by the Certification Committee.

4. The passing grade on examination for certification for CWCP shall be seventy (70) percent.

5. Any person making a failing grade on the examination shall be offered the opportunity to re-take an essay examination. If a passing grade is not made on the second examination, and the person wishes to pursue CWCP certification, that person must make application to re-take the training course, pay the required tuition fee, and complete the required training, including passing the CWCP examination.

6. Upon satisfactory completion of the course work and the passing of the examination, the student shall be issued a CWCP certificate.

G. Continuing Education For Retention Of Certification

1. Ten (10) hours of Continuing Education are required each year in order to retain the Certification as a CWCP (Re-certification), and must be completed prior to December 31st of the year following certification.

2. Upon completion of the Continuing Education requirement, the CWCP certificate holder shall be provided notification of re-certification by the course sponsor.

3. Failure to meet the requirements to re-certify will require the certificate holder to reapply and retake the CWCP course.

4. A record of registration and attendance must be maintained by the course sponsor throughout the entire course.

CERTIFICATION OF CWCP TRAINING COURSE SPONSORS

A. Course Sponsors

CWCP Training courses may be sponsored by any person or entity, including but not limited to, colleges and universities, insurers, adult education centers and associations.

B. Training Course Requirements

1. Except as otherwise provided, the CWCP certification training course must contain a minimum of forty (40) hours of instruction and must meet the following standards:

   a. Reference materials such as the Georgia Workers' Compensation Code, all rules and regulations promulgated under the Georgia Workers' Compensation Code and sample forms there under, training manuals, study manuals as appropriate, programmed textual materials (computer based training), and other illustrative materials shall be readily available for student use.

2. All classrooms used shall be rooms separate from other activities while instruction is being given and shall provide comfortable physical facilities for the students. Such classrooms must be properly equipped with sufficient desk or table space to accommodate the number of students taking the course and must contain sufficient teaching aids to facilitate a learning atmosphere for those students.

3. The subject matter of the certification course must pertain to materials relevant for CWCP certification for which applicant has applied or is intending to apply and must include all of the following to such extent as the information applies to the CWCP certification sought by the applicant.

   Historical Background
   a. Overview of Georgia Law
   b. Human Resources in Claim Handling
   c. Investigations
   d. Fraud Awareness
   e. Reserves/Estimates
   f. Medical Care
   g. Disability Management and Rehabilitation
   h. Financial Recovery
   i. Litigation and Mediation
   j. Forms and Procedures
   k. Communication

And such additional material as the Certification Committee may from time to time require by notice to the course sponsors.

4. All required course work must be completed within six (6) weeks of the beginning of the class. Special exceptions may be granted at the discretion of the Certification Committee.

5. Course sponsors must have their courses certified by the Certification Committee prior to beginning any course. To request this certification, the sponsor shall file with the Licensure Division of the State Board of Workers' Compensation, the following:

    a. An outline of the proposed certification training course, including instructional time for each major course component.
    b. An outline of a proposed Continuing Education course for annual CWCP re-certification purposes
    c. A list of all instructional material to be used and a computer disc of the computer based training.
    d. A description of the facility to be used as a classroom.
    e. A statement that adequate parking facilities are available and that handicap access is provided.
    f. The name or names of the instructors and a description of the instructor's qualifications.
    g. The Certification Committee may require further detail of the proposed course or filing of copies of any instructional materials to be used as are necessary to determine the adequacy of the proposed instruction.

Chapter 11

MEDICAL PROVIDER WORKERS' COMPENSATION TRAINING PROGRAM (MPWCT)

TRAINING PROCEDURE

A. Purpose and Applicability

To promote professionalism in the industry and improve the handling and continuity of workers' compensation claims, the State Board of Workers' Compensation has created a training program so that a medical provider involved in the treatment of the injured worker can become knowledgeable about the requirements of the workers' compensation system. This training establishes the framework for completing the MPWCT course, including application, training materials and continuing education. This procedure reflects the desire of the Board to proactively implement a mechanism to create a more uniform standard of knowledge among persons working in the workers' compensation field, thus benefiting the entire process of administering workers' compensation claims.

B. Training Optional

MPWCT Training is voluntary. It is in no way mandatory for person working in the workers' compensation field in the State of Georgia.

C. Definitions

Unless the context otherwise requires, the terms found in this Training Procedure are used as defined in §O.C.G.A. 34-9-1. Other terminology is used in accordance with the Georgia Workers' Compensation Code, or industry usage, if not defined in the Georgia Workers' Compensation Code.

MPWCT – the **Administrator** of the Training Program is under the review of the Licensure Division of the State Board of Workers' Compensation and the Oversight Committee.

Oversight Committee – the committee appointed by the Chair of the Licensure and Self-Insurance Committee of the Chairman's Advisory Council to oversee the certification of MPWCT course sponsors and oversee the administration of the MPWCT course. The committee shall consist of five (5) members. Three (3) of the members shall be appointed from the Licensure and Self-Insurance Committee of the Advisory Council. Two (2) of the members shall be Board personnel.

D. Examinations

1. Upon completion of the web-based training, attendees will answer a series of questions prior to attending the on-site session.

E. Continuing Education for Retention of MPWCT

1. Eight (8) hours of Continuing Education are required each year in order to retain the MPWCT designation, and must be completed prior to December 31st of the year following completion of the course.

2. Upon completion of the Continuing Education requirement, the MPWCT designation holder shall be provided notification by the course sponsor.

3. Failure to complete the continuing education training will require the candidate to reapply and retake the MPWCT course.

4. A record of registration and attendance must be maintained by the course sponsor throughout the entire course.

CERTIFICATION OF MEDICAL PROVIDER WORKERS' COMPENSATION TRAINING COURSE SPONSORS

A. Course Sponsors

MPWCT courses may be sponsored by any person or entity, including but not limited to, colleges and universities, insurers, adult education centers and associations.

B. Training Course Requirements

1. Except as otherwise provided, the MPWCT course must contain a minimum of forty (40) hours of instruction and must meet the following standards:

   a. Reference materials such as the Georgia Workers' Compensation Code, all rules and regulations promulgated under the Georgia Workers' Compensation Code and sample forms there under, training manuals, study manuals as appropriate, programmed textual materials (computer based training), and other illustrative materials shall be readily available for student use.

2. The MPWCT course is a computer-based training and webinar course. No classroom facilities are required.

3. The subject matter of the training course must pertain to materials relevant to workers' compensation and must include all of the following to such extent as the information applies to the training sought by the applicant.

   Curriculum
   a. What is workers' compensation?
   b. The State Board of Workers' Compensation
   c. Types of benefits
   d. Catastrophic injuries
   e. What is a compensable claim?
   f. Medical treatment under workers' compensation
   g. Reimbursement for a medical claim
   h. Return to work
   i. Board forms
   j. Coding/CPT/Fee schedule
   k. Disability rating
   l. How are medical providers involved in the legal system?
      i. Depositions
      ii. Expert witness
   m. Doctor notes and other documentation
   n. Independent medical exams
   o. Medical bill disputes
   p. Release of records
   q. Transportation
   r. Translation

   And such additional material as the Oversight Committee may from time to time require by notice to the course sponsors.

4. All required course work must be completed within six (6) weeks of the class. Special exceptions may be granted at the discretion of the Oversight Committee.

5. Course sponsors must have their courses certified by the Oversight Committee prior to beginning any course. To request this certification, the sponsor shall file with the Licensure Division of the State Board of Workers' Compensation the following:

   a. An outline of the proposed training course, including instructional time for each major course component.
   b. An outline of a proposed Continuing Education course.
   c. A computer disk of the computer-based training program material.
   d. A list of all instructional material to be used.
   e. The names of the instructors and a description of the instructors' qualifications.
   f. The Oversight Committee may require further detail of the proposed course or filing of copies of any instructional materials to be used as are necessary to determine the adequacy of the proposed instruction.

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COVERAGE

A. Employer's Duty to Insurer Payment of Compensation

O.C.G.A. §34-9-120 states that "Every employer subject to the compensation provisions of this Chapter shall insure the payment of compensation to his employees in the manner provided in this article; and, while such insurance remains in force, he or those conducting his business shall be liable to any employee for personal injury or death by accident only to the extent and in the manner specified in this article."

Further, pursuant to O.C.G.A. §34-9-121(a) "…every employer subject to the provisions of this Chapter…shall secure and maintain full insurance against such employer's liability for payment of compensation under this article, such insurance to be secured from some corporation, association, or organization licensed by law to transact the business of workers' compensation insurance in this state or from some mutual insurance association formed by a group of employers so licensed; or such employer shall furnish the Board with satisfactory proof of such employer's financial ability to pay the compensation directly in the amount and manner and when due, as provided for in this Chapter."

B. Self-Insurance (O.C.G.A. §34-9-127 and §34-9-380 et seq)

An employer desiring to become self-insured must apply by completing the Confidential Application For Private Self-Insuring Employers and Hospital Authorities and be accepted by the Board and the Georgia Self-Insurers Guaranty Trust Fund, O.C.G.A. §34-9-382. All questions must be answered fully and all financial information will be treated as strictly confidential. Each application must be submitted in duplicate, with the company's audited financial statements for the last three years and a filing fee of $500 payable to the Georgia Self-Insurers Guaranty Trust Fund. Each company is considered on its own merits, but strict attention is paid to the size of company, financial stability, amount of annual premium, number of employees, yearly payroll and the company's loss history. If a company is accepted as a self-insurer, a bond or letter of credit shall be posted in an amount not less than $250,000.

Counties, municipalities and other political subdivisions may qualify as self-insurers. Permission for self-insurance by municipalities and political subdivisions may be granted by application to the Board, on a form entitled Confidential Application for Governmental Self-Insuring Employers and without deposit of surety bonds. Assurance must be given the Board that provision will be made for payment of all workers' compensation liabilities.

Whenever an employer has complied with the provisions of the Workers' Compensation Act relating to self-insurance, the Board shall issue to such employer a certificate which shall remain in force for a period fixed by the Board; but the Board may, upon at least 60 days

notice to the employer and after a hearing, revoke the certificate upon satisfactory evidence for such revocation having been presented.

In order for a certificate to be granted by the Board under O.C.G.A. §34-9-127 and §34-9-382, the employer desiring to become a self-insurer must designate an office for the handling of claims (see Form WC-121 and Board Rule 127.) Every service organization or office handling claims for self-insurance under the law shall be staffed during normal working hours and be available for immediate telephone contact with the Board and the public. During normal working hours at this office, at least one staff member shall be authorized to execute negotiable instruments for the payment of compensation. Certificates will be continuous unless the self-insurer fails to meet the requirements of the Board.

C. Group Self-Insurers (O.C.G.A. §34-9-150)

It is the intent of the General Assembly to provide an alternative mechanism through which bona fide members of the following may extend workers' compensation benefits to their employees through group self-insurance programs as defined in O.C.G.A. §34-9-151: (a) counties; (b) hospital authorities; (c) municipalities; (d) professional associations; (e) school Boards; and (f) trade associations.

Group Self-Insurance Funds operating pursuant to the Georgia Workers' Compensation Act shall file with the Board a separate report, for each insured member employer, on Standard Coverage Form WC-11 on or before the effective date of coverage.

1. Group Self-Insurance Funds shall file a separate Form WC-11 for each insured member of the fund.

2. The filing of Form WC-11 is evidence that coverage is in effect until superseded or terminated.

3. The filing of a cancellation on Form WC-11 is evidence that coverage is terminated effective not less than 15 days after filing.

4. If the self-insured member employer operates under different trade names, a separate Form WC-11 must be filed for each trade name, properly cross-referenced.

D. Notice to or Knowledge of Accident (O.C.G.A. §34-9-123)

All policies insuring the payment of compensation, including all contracts of mutual, reciprocal or interinsurance must contain a clause to the effect that, as between the employer and insurer, the notice to or knowledge of the occurrence of the injury on the part of the employer shall be deemed notice or knowledge, as the case may be, on the part of the insurer.

E. Filing by Employer of Evidence of Compliance with Insurance Requirements (O.C.G.A. §34-9-126)

Every employer subject to the compensation provisions of the Workers' Compensation Act shall file with the Board in the form prescribed by the Board, annually or as often as the Board may deem necessary, evidence satisfactory to the Board of their compliance with O.C.G.A. §34-9-121.

Any employer subject to the compensation provisions of the Workers' Compensation Act who refuses or willfully neglects to comply with the provisions above shall be guilty of a misdemeanor. The Board may assess compensation against such employer in an amount 10% greater than that provided for in this Chapter and, in addition to the increased compensation, shall also fix a reasonable attorney's fee to be paid by the employer to the representative of the employee. The attorney's fee and the increased compensation shall be due and payable at once.

F. Payment of Compensation to Employees in Service of More Than One Employer (O.C.G.A. §34-9-224)

Whenever any employee whose injury or death is compensable under this Chapter shall at the time of the injury be in the joint service of two or more employers, such employers shall contribute to the payment of such compensation in proportion to their wage liability to such employee.

G. Payment of Compensation for Death Resulting From Injury (O.C.G.A. §34-9-265)

1. If death results instantly from an accident arising out of and in the course of employment or if during the period of disability caused by an accident death results, the compensation under this Chapter shall be as follows:

   a. The employer shall, in addition to any other compensation, pay the reasonable expenses of the employee's burial not to exceed $7,500. If the employee leaves no dependents, this shall be the only compensation.

   b. The employer shall pay the dependents of the deceased employee, who are wholly dependent on his/her earnings for support at the time of injury, a weekly compensation equal to the compensation which is provided for in O.C.G.A. §34-9-261 for total incapacity.

   c. If the employee leaves dependents only partially dependent on his/her earnings for their support at the time of his/her injury, the weekly compensation for these dependents shall be in the same proportion to the compensation for persons wholly dependent; as the average amount contributed weekly by the deceased's weekly wage at the time of his/her injury.

d. When weekly payments have been made to an injured employee before his/her death, compensation to dependents shall begin on the date of the last of such payments; but the number of weekly payments made to the injured employee under Code Section §34-9-261, §34-9-262, or §34-9-263 shall be subtracted from the maximum 400-week period of dependency of a spouse provided by Code Section §34-9-13, and in no case shall payments be made to dependents except during dependency.

e. The total compensation payable under this section to a surviving spouse as a sole dependent at the time of death and where there is no other dependent for one year or less after the death of the employee shall in no case exceed $150,000.

f. If there are no dependents in a compensable death case, the insurer or self-insurer shall pay the State Board of Workers' Compensation one-half of the benefits which would have been payable to such dependents or $10,000.00, whichever is less. All such funds paid to the Board shall be deposited in the general fund of the state treasury. If after such payment has been made, it is determined that a dependent or dependents qualified to receive benefits exist, then the insurer or self-insurer shall be entitled to reimbursement by refund for money collected in error.

H. Applicability of Chapter IX to Occupational Disease; Circumstances in Which Death or Disability Resulting From Occupational Disease is Compensable (O.C.G.A. §34-9-281)

1. Where the employer and employee are subject to this Chapter, the disablement or death of an employee resulting from an occupational disease shall be treated as the occurrence of an injury by accident and the employee or, in the case of his/her death, the employee's dependents shall be entitled to compensation as provided by this Chapter. The practice and procedure prescribed in this Chapter shall apply to all the proceedings under this article except as otherwise provided.

2. Except as otherwise provided in O.C.G.A. §34-9-281, an employer shall be liable for compensation under this article only where:

   a. The disease arose out of and in the course of the employment in which the employee was engaged under such employer, was contracted while the employee was so engaged, and has resulted from a hazard characteristic of the employment in excess of the hazards of such disease attending employment in general.

   b. The claim for disablement is filed within one year after the date the employee knew or, in the exercise of reasonable diligence, should have known of the disablement and its relationship to the employment; but in no event shall the claim for disablement be filed in excess of seven years after the last injurious exposure to the hazard of such disease in such employment. In cases of death where the cause of action was not barred during the employee's life, the claim must be filed within one year of the date of death.

I. Insurance with More Than One Company; Use of Servicing Agents and Third Party Administrators (Board Rules 121 and 131)

1. A compensation policy must cover all of the operations of an employer. An employer has the right to place insurance with more than one insurer; but if this is done with respect to distinct operations, the policies must be concurrent and the written portions must read alike. If there is any difference in coverage, it can be expressed as applying to a fractional part thereof. If an employer has more than one place of business, each operation can be covered separately unless the business is interchangeable. Each insurer on the risk must cover alike all the employees coming under the law. Each insurer shall inform the Board of the proper address to be used by the Board for serving all hearing notices and other Board notices.

2. Notice of Use of Servicing Agent or Third Party Administrator (Form WC- 121). An insurer, self-insurer, or group fund shall file this form to give notice of the employment of a servicing agent or third party administrator, and of the termination of services of same. When obtaining the services of a servicing agent or third party administrator, this form shall be filed no later than the commencement date of those services. When terminating the services of a servicing agent or third party administrator, this form shall be filed no later than 30 days prior to the date of the cessation of services. Also use the form to add an additional third party administrator.

3. The transfer of files from one third party administrator/servicing agent to another must be handled in a professional and timely manner.

    a. Open indemnity files must be current as of the date of transfer and the transferring (former) third party administrator/servicing agent must include in the file a complete current Form WC-4 (completed within the last 30 days) reflecting all payments made as of the date of transfer. The transferring third party administrator/servicing agent must at the date of transfer provide the receiving third party administrator with a payment history on all Medical Only claims with an occurrence date of 90 days or less as of the date of transfer. Penalties for noncompliance by the transferring third party administrator/servicing agent would be in accordance with O.C.G.A. § 34-9-18(a).

    b. The receiving (new) third party administrator/servicing agent must notify all active (open) claimants of the change in administration within 14 days of receiving the files. Vendors must be notified within 60 days of receipt of medical bills or service invoices.

4. Employers unable to obtain workers' compensation insurance coverage in any other manner may apply to the assigned risk pool:

    National Council on Compensation Insurance, Inc.
    901 Peninsula Corporate Circle
    Boca Raton, FL 33487-1362
    Phone: 1-800-622-4123

Every employer insured by a licensed insurer shall have proof of coverage documented by its insurer directly with a Licensed Rating Organization through their policy information system. Every employee leasing company shall have proof of coverage documented with a Licensed Rating Organization of the initiation or termination of any contractual relationship with a client company; for the purposes of this Rule, the term employee leasing company shall refer to both: (1) any employee leasing company as defined in O.C.G.A. §34-8-32; and (2) any professional employer organization as defined in §O.C.G.A. §34-7-6. Reports will be made to the Licensed Rating Organization pursuant to procedures outlined by the Licensed Rating Organization and approved by the Georgia State Board of Workers' Compensation.

a. The proof of coverage documented with a Licensed Rating Organization is evidence that coverage is in effect until superseded or terminated.

b. Termination
   i. Non-renewals
      The expiration date documented by a Licensed Rating Organization shall be considered the date of termination on all non-renewals.

   ii. A mid-term cancellation documented with a Licensed Rating Organization is evidence that coverage is terminated, effective not less than 15 days after filing except where the provisions of Title 33 provide for an earlier effective date.

Chapter 2

REPORTING REQUIREMENTS FOR EMPLOYERS
CLAIMS FORMS (BOARD RULE 61)

A. Form WC-1 Employer's First Report of Injury or Occupational Disease

Employer should complete Section A of the form immediately upon knowledge of an injury and submit the form to their insurer. The insurer then completes Form WC-1 for cases involving more than seven days of lost time and transmits it to the Board.

Insurers, self-insurers or group funds shall complete Section B, C or D and send to the Board and a copy to the employee within 21 days of the employer's knowledge of disability.

B. Additional Forms to be Filed by Insurers/Self-Insurers

1. Form WC-2 Notice of Payment or Suspension of Benefits. Use Form WC-2 to commence or suspend payment of weekly benefits after filing an Employer's First Report of Injury (Form WC-1). For all other cases, including any change in weekly benefits, classification or rating of disability, file Form WC-2. Furnish a copy to injured worker.

2. Form WC-2a Notice of Payment or Suspension of Death Benefits. Use in death cases in lieu of Form WC-2. Use when changes in dependency occur.

3. Form WC-3 Notice to Controvert Payment of Compensation. Complete Form WC-3 to controvert where a Form WC-1 has previously been filed. Furnish copies to the injured worker and any other person with a financial interest in the claim (see Subsections (d), (h), and (i) of O.C.G.A. §34-9-221.)

4. Form WC-4 Case Progress Report. File as follows:
   a. Within 1 year of the first date of disability;
   b. Within 30 days from last payment for closure;
   c. Upon request of the Board;
   d. Every 12 months from the date of the last filing of a WC-4 on all open cases;
   e. To reopen a case;
   f. Within 30 day of final payment make pursuant to an approved settlement.
   g. Within 90 days of receipt of an open case by the new third party administrator.

5. Form WC-6 Wage Statement. The employer/insurer must file this form when the weekly benefit is less than the maximum under O.C.G.A. §34-9-262 and furnish a copy to the employee. If a party makes a written request of the employer/insurer, then the employer must send the requesting party a completed Form WC-6 within 30 days, but should not send a copy to the Board.

6. Form WC-10 Notice of Election or Rejection of Workers' Compensation Coverage (O.C.G.A. §34-9-2.1,2.2, 2.3, Rule 2).

    a. A sole proprietor or partner must file this form to elect coverage under the provisions of O.C.G.A. §34-9-2.2.
    b. The employer/insurer must file this form in order that the corporate officer or limited liability company member is exempt from coverage, or to revoke their previously filed exemption. Rejection becomes effective the date of filing with the insurer, if there is one; and, if none, with the Board.
    c. The farm labor employer must file this form in order to request coverage for farm laborers, or to revoke their previously filed request.
    d. Pursuant to Rule 2(d) all WC-103 filed with the Board must be renewed every five years.

7. Form WC-20(a) Medical Report (may also use HCFA 1500 or UB 04). The attending physician or other practitioner completes the report to document treatment and forwards it along with office notes and other narratives to the employer/insurer as follows:

    a. Within seven days of initial treatment;
    b. Upon the employee's discharge by the attending physician or at least every three months until the employee is discharged;
    c. Upon the employee's release to return to work; and
    d. When a permanent partial disability rating is determined.

    The employer/insurer shall file the report including office notes and narratives with the Board within 10 days after receipt as follows:

    a. When the report contains a permanent partial disability rating;
    b. When a rehabilitation plan is filed with the Board. All medical reports and attachments which have not been filed with the Board must be filed at the time the plan is filed with the Board, and all medical reports and attachments received thereafter shall be filed with the Board within 10 days of receipt;
    c. Upon request of the Board; and
    d. To comply with other rules and regulations of the Board.

    The employer/insurer shall maintain copies of all medical reports and attachments in their files and shall not file medical reports except in compliance with Board Rules 61(b)(12),(15), and (16) and 200(c).

8. Medical Reports.

    a. The employer/insurer shall file with the Board all medical reports, narratives and other correspondence only as provided in Board Rules 61(b)(12),(15), and (16) and 200(c).
    b. The employer/insurer shall file all required medical reports not previously filed.

9. Form WC-26 Consolidated Yearly Report of Medical Only Cases and Annual Payments on Indemnity Claims. File on or before the 1st of March following the end of the calendar year in respect to payments for injuries not reported on Form WC-1. File annually even if no reportable injuries or payment occurred during the reporting year.

10. Form WC-R1 Request for Rehabilitation. The employer/insurer shall file:

    a. Within 48 hours of a compensable catastrophic injury, simultaneously with the Form WC-1, naming a catastrophic rehabilitation supplier
    b. Within 20 days of notification that rehabilitation is required to request a rehabilitation supplier.
    c. When the employer/insurer requests a rehabilitation supplier for cases with dates of injury prior to July 1, 1992.
    d. When the employer/insurer requests a change of rehabilitation supplier.
    e. To request reopening of rehabilitation.
    f. Upon request of the Board.

11. Any person who willfully fails to file any form or report required by the Board, fails to follow any order or directive of the Board or any of its members or Administrative Law Judges, or violates any rule or regulation of the Board shall be subject to a civil penalty of not less than $100 nor more than $1,000 per violation. The assessed penalty becomes final unless the person fined files a written request for a hearing within ten days of the assessment. Any person, firm, or corporation who willfully makes any false or misleading statement or representation for the purpose of obtaining or denying benefits shall be guilty of a misdemeanor and upon conviction may be assessed a civil penalty of not less than $1,000 nor more than $10,000 per violation or imprisonment not to exceed 12 months or by both such fine and imprisonment (O.C.G.A. §§34-9-18 & 19).

Chapter 3

METHOD OF PROVIDING MEDICAL TREATMENT

A. Selection of Physician from Panel of Physicians…O.C.G.A. §34-9-201(b)

O.C.G.A. §34-9-201(b) of the Workers' Compensation Law provides:

1. The employer may satisfy the requirements for furnishing medical care in one of the following manners:

   a. The employer shall maintain a list of at least 6 non-associated physicians or professional associations or corporations of physicians who are reasonably accessible to employees. This list shall be known as the P-1 "Panel of Physicians Poster." At least one of the physicians must practice the specialty of orthopedic surgery. Not more than two physicians on the panel shall be from industrial clinics. One physician on the panel must be a minority. The employee may make one change from one physician to another on the same panel without prior authorization from the Board. This poster is available in Spanish.

      However, the Board may grant exceptions to the required size of the panel where it is demonstrated that more than six physicians or groups of physicians are not reasonably accessible. In the event that the Board has granted an exception to any panel requirements, the exception must be posted in the same location as the panel.

   b. The employer may maintain a list of at least 10 physicians or professional associations reasonably accessible to the employees and providing the same types of healthcare services specified in Board Rule 201(a) (1) and the following healthcare services: general surgeons and chiropractors. This list shall be known as the P-2 "Conformed Panel of Physicians Poster." This poster is available in Spanish

   c. An employer or the workers' compensation insurer of an employer may contract with a managed care organization certified by the Board. This list shall be known as the P-3 WC/MCO Panel Poster. Medical services provided in this manner shall be known as "Managed Care Organization Procedures." Employees shall be given notice of the managed care organization's network of eligible medical service providers and information regarding the contract and manner of receiving medical services, including a toll free 24-hour telephone number that informs employees of available services.

   d. An employee may obtain the services of any physician from the panel and may thereafter elect to change to another physician on the panel without prior authorization of the Board. The physician so selected will become the primary treating physician in control of the employee's medical care.

O.C.G.A. §34-9-201(g) provides that the Board shall ensure, whenever feasible, the participation of minority physicians on panels of physicians and managed care organizations maintained by employers. For the definition of "minority," see Chapter 7 (A) (1) of this manual and Rule 201(a)(1)(i).

2. Businesses with multiple locations should choose physicians for their panel who are in close proximity to each individual location. The employer should contact each physician (group, professional association, or professional corporation) prior to listing them on the posted panel, conformed panel, or within the managed care organization provider network procedures to assure their willingness to treat workers' compensation patients' claims.

3. Notwithstanding any selection made pursuant to his/her rights under the posted panel, conformed panel, or managed care organization procedures, an employee, after a compensable injury and within 120 days of receipt of any income benefits, shall have the right to one examination at a reasonable time and place, within this state or within 50 miles of the employee's residence, by a duly qualified physician or surgeon designated by the employee and to be paid for by the employer/insurer. Such examination shall not repeat any diagnostic procedures which have been performed since the date of the employee's injury unless the costs of such diagnostic procedures which are in excess of $250 are paid for by a party other than the employer or the insurer.

4. If an emergency situation arises in which there is not time to comply with selection requirements, the injured employee is authorized to seek treatment from a physician of his/her choice; this authorization lasts for the duration of the emergency. An emergency may be defined as "an unforeseen occurrence or combination of circumstances which calls for immediate action or remedy; pressing necessity; exigency." All follow-up medical care should be supplied by a physician from the panel, conformed panel (or the authorized treating physician's referral), or from the managed care organization's provider network.

5. The "P-1 (Panel of Physicians)," "P-2 (Conformed Panel of Physicians)," or P-3 (WC/MCO Panel)" must be posted in prominent locations accessible to all employees such as bulletin Boards, employees' break station, time card clock, personnel office, etc. The P-1, P-2 or P-3 should also be posted at remote job sites where employees are regularly required to work away from their principal place of business. The employer shall take all reasonable measures to ensure that employees:

   a. Understand the function of the P-1, P-2 or P-3;

   b. Understand his/her right to select a physician from the panel, conformed panel, or managed care organization in case of an on-the-job injury and to make a one-time change of physician within the panel without Board approval.

   c. Are given appropriate assistance in contacting panel, conformed panel, or managed care organization members when necessary.

B. Changes in Treatment

Except as provided in Subsection (b) of O.C.G.A. §34-9-201, changes in physician or treatments are made only by agreement of the parties or by order of the Board. Board authorized changes are effective on the date the request is filed with the Board, unless a later date is specified in the Board's order. The request for change in physician shall include the address of the physician to whom a change or additional treatment is desired. A request for, or objection to, a change of physician or additional treatment must be filed on Form WC-200b, with supporting documentation attached and with copies provided to all parties. If the argument in support of, or in objection to, the change is based on testimony, an affidavit must be attached to the form and, if the argument refers to documents, a copy of the documents must be attached. Parties are required to make a "good faith" effort to resolve a change of physician dispute prior to filing a Form WC-200b.

Chapter 4

MEDICAL

1. Medical Reports (Board Rule 200 (a)(b)(c))

   The employer/insurer shall not file the medical reports with the Board, except as follows:

   1. When the report contains a permanent partial disability rating;
   2. When a Rehabilitation Plan is filed with the Board. All medical reports and attachments which have not been filed with the Board must be filed at the time the plan is filed with the Board, and all medical reports and attachments received thereafter shall be filed with the Board within 10 days of receipt;
   3. Upon request of the Board; and
   4. To comply with other rules and regulations of the Board.

   The employer/insurer shall maintain copies of all medical reports and attachments in their files and shall not file medical reports with the Board except in compliance with Board Rules 61(b)(12),(15), and (16) and 200(c).

   The employee shall, upon the request of the employer/insurer, furnish copies of all medical records and reports in his/her possession within 30 days of the date of the request, the cost of which shall be charged to the employer/insurer according to the fee schedule. The employer/insurer shall, upon the request of the employee, furnish copies of all medical reports in their possession within 30 days of the date of the request, at no expense to employee. Upon failure of either party to furnish information as provided above, the physician or other medical providers shall, upon request, furnish copies of all medical reports and bills in their possession at no expense to the employee, the cost of such records shall be billed according to the fee schedule, and charged against the party determined to be responsible for payment of medical expenses (see Board Rule 200 (c)).

2. Independent Medical Examinations (IME) (Board Rule 202)

   1. An IME may include physical, psychiatric and psychological examinations. An examination may also include reasonable and necessary testing as recommended by the examining physician.

   2. The employer/insurer shall give the employee and/or his/her attorney ten days written notice of the time and place of any requested examination. Advance payment of required travel expenses shall accompany such notice.

   3. The employer/insurer shall not suspend weekly benefits for refusal of the employee to submit to examination or cooperate with treatment except by order of the Board.

4. The employer/insurer cannot restrict treatment to the panel of physicians, conformed panel, or managed care organization where they have controverted the claim. However, if the controverted claim is subsequently found to be or is accepted as compensable, the employee is authorized to select one of the physicians who has provided treatment for the work-related injury prior to the finding or acceptance of compensability, and such physician becomes the authorized treating physician. The employee may thereafter make one change from that physician to another physician without approval of the employer and without an order of the Board. However, any further change of physician or treatment must be in accordance with O.C.G.A. §34-9-200 and Board Rule 200.

3. Payment of Medical Expenses (Board Rule 203(a)

The insurer/self-insurer are responsible for the payment of all reasonable, necessary, and related medical expenses prescribed by an authorized treating physician, including diagnostic testing, to determine causation. The insurer/self-insurer may automatically conform charges according to the fee schedule adopted by the Board and shall pay within 30 days from the date of receipt of the charges. The insurer/self-insurer must provide written notification to the medical provider within 30 days of the receipt of medical charges, the reasons for non-payment of medical expenses and a written itemization of any documents or other information needed to process the claim for medical benefits. Failure of the insurer/self-insurer to notify the medical provider in writing within 30 days of the receipt of the charges of the need for further documentation will be deemed a waiver of the right to defend a claim for failure to pay charges in a timely fashion on the ground that the charges were not accompanied with the proper documentation. However, this waiver does not extend to any other defense the insurer/self-insurer may have with respect to a claim of untimely payment. If the insurer/self-insurer is controverting the medical expenses, they must file a Form WC-3, Notice to Controvert, with the Board within the 30 days allowed for payment. All persons having a financial interest, including the physician, must receive a copy of the Form WC-3.

Medical expenses shall include, but are not limited to, the reasonable cost of travel between the employee's home and the place of examination or treatment, including physical therapy appointments or the pharmacy visits. When travel is by private vehicle, the rate of mileage shall be 40 cents per mile (Board Rule 203(e)). Travel expenses beyond the employee's home city shall include the actual cost of meals and lodging. Travel expenses shall further include the actual reasonable cost of meals when total elapsed time of the trip to obtain outpatient treatment exceeds four hours per visit. Cost of meals shall not exceed $30 per day. Medical expenses include the reasonable cost of attendant care directed by the treating physician during travel and convalescence.

Reasonable medical charges must be paid within 30 days of the date that the insurer/self-insurer receives the charges and reports. If the medical charges are not paid within 30 days of the receipt of the documentation required by the Board, the following penalties will apply: A 10% penalty on reasonable medical charges paid after 30 days but before 60 days; a 20% penalty on reasonable medical charges paid after 60 days but before 90 days; and, in addition

to the 20% penalty, a 12% per annum interest rate is charged on reasonable medical charges paid after 90 days. The penalties and interest are payable directly to the provider.

4. Procedure When Amount of Medical Expenses, Necessity of Treatment or Authorized Treatment are Disputed (Board Rule 203(b), 205)

Medical expenses shall be limited to the usual, customary and reasonable charges. Employers/insurers may automatically conform charges according to the fee schedule adopted by the Board, and the charges listed in the fee schedule shall be presumed usual, customary and reasonable and shall be paid within 30 days from the date of receipt of the charges. Employer/insurer shall not unilaterally change any CPT-4 code of the provider. All charges automatically conformed according to the fee schedule adopted by the Board shall be for the CPT-4 code listed by the provider. In situations where charges have been reduced or payment of a bill denied, the insurer, self-insurer, or third party administrator shall provide an Explanation of Benefits with payment information explaining why the charge has been reduced or disallowed, along with a narrative explanation of each Explanation of Benefit code used.

Any health service provider whose fee is reduced to conform to the fee schedule may request peer review of charges and present evidence as to the reasonableness of his/her charges. If the dispute is not resolved through the recommendations of peer review, then mediation or hearing may be requested. An employer/insurer, who disputes that any charge is the usual, customary and reasonable charge prevailing in the State of Georgia shall, within 30 days of the receipt of the charges, file with the appropriate peer review committee a request for review of only those specific charges which are disputed. No CPT, DRG, or ICD-9 Codes are to be changed without first notifying, and then obtaining permission from, the authorized treating physician/hospital. Any physician/hospital whose charges are disputed and any party disputing such charges must comply with requirements of law, Board rules, and, if applicable, rules of the appropriate peer review committee before the Board will order payment of any disputed charges. The injured worker's name and address must be included in the request for peer review. Effective July 1, 1992, Board Rule 203(b) was changed to allow all parties to correspond directly with Board approved peer review committees. These committees may be contacted at the following addresses.

Dr. Mitchell S. Nudelman (effective until December 1, 2010)
Medical Director Solutions, LLC
577 Seminole Drive
Marietta, GA 30060
(770) 499-0398; FAX (770) 499-8299

Mr. Michael Walsh, Executive Director
Georgia Chiropractic Association, Inc.
1926 Northlake Parkway, Suite 201
Tucker, GA 30084
(770) 723-1100 FAX (770) 723-1722

Mr. Clark Thomas, Executive Director
Georgia Psychological Association
2200 Century Parkway, NE, Suite 660
Atlanta, GA 30345
(404) 634-6272 FAX (404) 634-8230

Mr. Stuart Platt, M.S.P.T., P.T., Principal
Appropriate Utilization Group, LLC
881 Piedmont Avenue
Atlanta, GA 30309
(404) 728-1974

Within 30 days of the date that a decision is issued by a peer review organization, the employer/insurer shall either make payment of disputed charges based upon the recommendations of the peer review committee or request mediation. If the dispute is not resolved through mediation, a hearing may be requested. The peer review committee shall serve a copy of its decision upon the employee, or if represented by counsel, on the employee's attorney. A physician whose fee has been reduced by the peer review committee shall have 30 days from the date that the recommendation is mailed to request mediation. If the dispute is not resolved through mediation, a hearing may be requested. In the event of a hearing, the recommendations of the peer review committee shall be evidence of the usual, customary and reasonable charges.

5. Reimbursement of Group Carrier or Other Healthcare Provider (Board Rule 206)

A Form WC-206 shall be submitted to the Board by the party seeking reimbursement at any time during the pendency of a claim. Copies shall also be sent by the party requesting reimbursement to all counsel and unrepresented parties. When the Board receives a request for reimbursement and designation as a party at interest, the Board will provide the party requesting reimbursement with notice of the hearing.

Chapter 5

INSPECTION OF PREMISES, NONCOMPLIANCE, AND FALSE OR MISLEADING STATEMENTS OR REPRESENTATIONS

(Workers' Compensation Fraud)

A. Enforcement Division

In accordance with O.C.G.A. §34-9-24, there is established within the Board, a fraud and compliance division. Pursuant to Board Rule 24 this division shall be known as the Enforcement Division. The Enforcement Division shall assist the Board in administratively investigating allegations of fraud and noncompliance and in developing and implementing programs to prevent fraud and abuse in workers' compensation. The Enforcement Division is a sworn law enforcement agency with the authority to execute search warrants and make arrests pursuant to warrants being issued as a result of a criminal investigation of an alleged violation of this Chapter.

In the absence of fraud or malice, no person or entity who furnishes to the Board information relevant to suspected fraud or noncompliance with regards to workers' compensation laws shall be liable for damages in regards to the furnishing of said information.

Board Rule 24 outlines the procedure utilized by the Enforcement Division to request a hearing. Subsection (b) of Rule 24 authorizes the Enforcement Division to request a hearing before an administrative law judge for the assessment of civil penalties against any person or entity for violating provisions of Title 34-9 by filing Board Form WC-24. Board Form WC-24 is for use only by the Enforcement Division to request a hearing. All hearings will be conducted pursuant to O.C.G.A. §34-9-102 and Board Rule 102. Subsection (c) of Rule 24 states that all appeals of a decision of the administrative law judge concerning civil penalties for violations of Title 34-9 must follow O.C.G.A. §34-9-103 and O.C.G.A. §34-9-105 and their accompanying Board Rules.

Board Rule 24 provides the Enforcement Division the authority to issue a Board directive when investigating incidences of noncompliance. Pursuant to subsection (d), during an investigation of alleged noncompliance with the provisions of Chapter 9 of Title 34, the Enforcement Division of the State Board of Workers' Compensation may issue a notice for verification of coverage directing the employer, within fifteen days of the date of the notice, to provide either proof of worker's compensation coverage or proof as to why the employer is not subject to the Act. This notice shall be considered a directive of the Board.

B. Authority to Inspect

Pursuant to O.C.G.A. §34-9-128, the Board and its authorized representatives shall have the power and authority to enter any place of employment and to inspect the same, together with all employment, payroll, and injury records at any reasonable time for the purpose of

investigating compliance with this Chapter and making inspections for the proper enforcement of this Chapter.

The willful refusal of an employer to permit inspections and investigations as stated in this Code Section or to comply with O.C.G.A. §34-9-120, O.C.G.A. §34-9-121, and O.C.G.A §34-9-126 after being notified of non-compliance by the Board may subject the employer to a penalty to be assessed by the Board not exceeding $50.00 per day so long as the refusal shall continue.

C. Compliance with Insurance Requirements

According to O.C.G.A. §34-9-121(a) unless otherwise ordered or permitted by the Board, every employer subject to the provisions of this Chapter relative to the payment of compensation shall secure and maintain full insurance against such employer's liability for payment of compensation under this article. Premiums for workers' compensation insurance cannot be withheld from an employee's pay.

O.C.G.A. §34-9-126(a) states every employer subject to the compensation provisions of this Chapter shall file with the Board in the form prescribed by the Board, annually or as often as the Board in its discretion may deem necessary, evidence satisfactory to the Board of its compliance with O.C.G.A. §34-9-121.

D. Penalties for Non-Compliance, Failure to Maintain Required Workers' Compensation Insurance Coverage

In addition to the penalty outlined in Section B above, O.C.G.A. §34-9-18(c) provides that the Board may assess a civil penalty of not less than $500 nor more than $5,000 per violation for the violation of O.C.G.A. §34-9-121 or §34-9-126(a).

Subsection (b) of O.C.G.A. §34-9-126 provides criminal sanctions for non-compliance .....by stating any employer subject to the compensation provisions of this Chapter who refuses or willfully neglects to comply with Subsection (a) of §34-9-126 shall be guilty of a misdemeanor.

E. Penalties for Making False or Misleading Statements when Obtaining or Denying Benefits

O.C.G.A. §34-9-18(b) provides a civil penalty of not less than $1,000.00 nor more than $10, 000 per violation when any person knowingly and intentionally makes any false or misleading statement or misrepresentation for the purpose of obtaining or denying workers' compensation benefits or payments. O.C.G.A. §34-9-19 provides criminal sanctions against any person, firm, or corporation who willfully makes false or misleading statements or representations for obtaining or denying workers' compensation benefits or payments. Upon conviction, a fine of

not less than $1,000 or more than $10,000 or by imprisonment not to exceed 12 months or both may be levied.

F. Penalty for Employee's Fraudulent Receipt of Benefits

O.C.G.A §34-9-21 provides any employee who, with the intent to defraud, receives and retains any income benefits to which he or she is not entitled shall be guilty of a misdemeanor and upon conviction thereof, shall be punished for each offense by a fine of not less than $1,000 nor more than $10,000 or by imprisonment not to exceed one year or by both such fine and imprisonment.

G. Payment of Penalties

All civil penalties and cost assessed under these Code Sections shall be tendered to the State Board of Workers' Compensation.

Any person, firm or corporation assessed civil penalties according to these Code Sections may also be assessed the costs of investigation and/or collection. The cost of collection may also include reasonable attorney's fees.

Chapter 6

GEORGIA SUBSEQUENT INJURY TRUST FUND (O.C.G.A. §34-9-350 et seq.)

A. Purpose and Construction of Article O.C.G.A. §34-9-350 et seq

The Subsequent Injury Trust Fund, as part of Georgia's Workers' Compensation Law, is designed to reduce the impact of singularly large workers' compensation exposure in the event a worker with a disability, injured on the job, aggravates his/her earlier impairment. The fund works in several ways: (1) helps to keep employers' insurance premiums under control, (2) helps maintain an employer's insurability; and in the case of a self-insured employer, the self-insurer does not face workers' compensation exposure above the deductible levels.

As an employer, you must have knowledge of the previous permanent impairment and determine that it is likely a hindrance to employment. This knowledge must exist prior to the new injury for the resources of the Subsequent Injury Trust Fund to become involved. Prior knowledge of the conditions listed in O.C.G.A. §34-9-361 will satisfy this requirement. The employer's knowledge provision of O.C.G.A. §34-9-361 does not violate ADA laws.

In accordance with OCGA 34-9-368 the Subsequent Injury Trust Fund will not accept claims for reimbursement that have an accident date of July 1, 2006 or later. Notification of a claim must be in writing, transmitted on the facsimile machine, or transmitted electronically and forwarded to:

The Georgia Subsequent Injury Trust Fund
Marquis II Tower, Suite 1250
285 Peachtree Center Avenue, NW
Atlanta, GA 30303

Phone: (404) 656-7000
FAX: (404) 656-7100
Website: www.sitf.georgia.gov

Chapter 7

REHABILITATION

A. Reference to Insurer/Self-Insurer Section

See Insurer/Self-Insurer Section, Chapter 8, for rehabilitation information.