# Georgia State Board of Workers' Compensation

# Procedure Manual

## Insurer/Self-Insurer Reference Section

The Procedure Manuals are to be used as reference tools 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 Manuals are updated annually to reflect any changes in the workers' compensation law or rules. Copies of the Procedure Manuals may be obtained online 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 sends the WC-1 to the insurer. 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, 2009, the WC-1 must be filed EDI (Electronic Date Interchange), see Chapter 5. The filing of a form WC-1 with the Board creates a Board file with a corresponding claim number.

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 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 late-payment 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 cannot be filed electronically and must be filed in paper, and the Board’s system will create a Board Tracking Number (BTN). The insurer 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 must check to see that the employer has completed all questions in Section A. The insurer 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. After a Form WC-1 is filed with the Board, the insurer should file Form WC-2. The insurer must furnish a copy to the claimant [see Board Rule 61(b) (1)].

1. If the insurer is paying less than the maximum rate, a Form WC-6, wage statement, is required to be filed with the Board [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 provide 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. After first filing a Form WC-1 with the Board, 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 a medical-only claim. Complete Section D if a medical-only claim has been settled. Complete Section D if filing a WC-200a. EDI filing is not permitted for Section D or Medical-Only section 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 shall file this form when the weekly benefit is less than the maximum under O.C.G.A. §34-9-261 or §34-9-262.

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 (see Board Rule 102(F)(1)).

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 for TPD benefits 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 Conservators

The following persons shall be conclusively presumed to be the next of kin wholly dependent for support upon the deceased employee: (1) a spouse, except that if the husband and wife were living separately for a period of 90 days immediately prior to the accident which resulted in the death of the deceased employee the presumption of total dependence shall be rebuttable; (2) a child of the employee if the child is under 18 or enrolled full time in high school, or if the child is over 18 and is physically or mentally incapable of earning a livelihood, or if the child is under the age of 22 and is a full-time student or the equivalent in good standing enrolled in a postsecondary institution of higher learning. Children include dependent stepchildren, legally adopted children, posthumous children, and acknowledged children born out of wedlock. Married children are not included.

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 no longer recognizes 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.

[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.

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.

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 conservator duly appointed and qualified by the probate court of the county of residence of such minor or legally incompetent person. Said conservator shall be required to file with the Board a copy of the conservatorship returns filed annually with the probate court and give notice to all parties within 30 days of any change in status.

After July 1, 2012, O.C.G.A. §34-9-226 provides that the Board may appoint conservators for minors or legally incompetent adults under the following limited circumstances:

1. receipt and administration of benefits;

2. to compromise and terminate any claims and receive any sum paid in settlement approved by the Board that does not exceed $100,000; and

3. when there is no guardian for minor or incompetent adult, the Board may appoint a temporary guardian ad litem to bring or defend an action under the Workers' Compensation Act;

4. where the natural parent is the guardian of a minor and the settlement amount is less than $15,000, no Board appointed conservator shall be necessary.

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

Effective 5/12/11, the term conservator was substituted for guardian, and the term conservatorship was substituted for guardianship. O.C.G.A. §34-9-226.

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. There is a limit of $230,000 if the only dependent 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 of $10,000 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 $500.00 per-week 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 to that dependent, and the amount payable to the other dependents would increase (e.g. each receives 1/3).

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:

$$\$150 \div \$600 \times \$400 = \$100.00$$

In cases where there are no dependents, the benefit payable to the State Board of Workers' Compensation is $10,000. 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 from the Board's CFO 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 files a 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. See Section 5-1, A.5 regarding EDI and attachments. The insurer/self-insurer must give the employee ten days advance notice of the suspension of income benefits. A copy of the form WC-2 and attached medical information is to be sent to the employee and their attorney, if represented. 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. O.C.G.A. §34-9-240; Board Rule 240.

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. Changing Benefits from Temporary Total to Temporary Partial

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 may complete Form WC-104. The Form WC-104 must be filed with the Board and served on the employee and their counsel, if represented, 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 Required Information

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 – Commencing Benefits – Section B

   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.

3. Form WC-2 – Suspending Benefits – Section C

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 restrictions 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. This section could be used if the employee returned to work.

4. 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.

1. 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.

2. 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.

3. 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.

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. Permanent partial disability (PPD) is defined as disability partial in character but permanent in quality resulting from loss or loss of use of body members or from the partial loss of use of the employee's body. A PPD rating is given by a physician pursuant to the AMA Guidelines, 5th Edition.

Benefits due for permanent partial disability are not payable so long as the employee is entitled to benefits under Code Section 34-9-261 or 34-9-262. If any employee is receiving permanent partial disability benefits and undergoes a change in condition entitling the employee to benefits under Code Section 34-9-261 or 34-9-262, any payments for permanent partial disability shall cease until further change in condition occurs.

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. Where an injured employee received more than one PPD rating for the same injury, the injured employee is entitled to PPD benefits that pay the employee the most benefits.

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 (includes "Medical Only" cases) is filed with the Board. The employer/insurer should use the following guidelines:

1. Board rules require filing as follows for both controverted and accepted claims:

    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 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 or Board tracking number (BTN) 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

# ADDITIONAL FORM FILINGS

A. Form WC-7 – Application for Self-Insurance

An employer desiring to become self-insured with the State Board must apply by completing the Confidential Application For Private Self-Insured Employers and Hospital Authorities and be accepted by the Georgia Self-Insurers Guaranty Trust Fund and the Board (packet available through Licensure Division (404 656-4893). Once a 5-digit SBWC ID number is obtained, the self-insured employer may begin filing documents with the Board.

B. Form WC-11 - Standard Coverage Form

Group self-insurance funds will complete this form when adding a new member or D/B/A, or cancelling a member or D/B/A. Note, group self-insurance funds must complete a separate WC-11 for each insured member of the fund (Board Rule 126).

C. WC-26 – Consolidated Yearly Report of Medical Only Cases and Annual Payments on Indemnity Claims

This form should be filed on or before March 1st following each calendar year with respect to all medical and indemnity payments for the previous year for work-related injuries. File annually even if no reportable payment occurred during the reporting year. Below are instructions to complete the form:

1. Section A
   Insurer/Self-Insurer/Self-Insurance Group Fund: Name as it was reported to the Board. Please no acronyms.

   SBWC ID#: The five-digit number assigned to you by the Board. Please do not put your NAIC number.

   Reporting Year: The calendar year immediately before the current year.

2. Section B
   Total Number of Medical Only Claims: List the number of new medical only claims that occurred during the reporting year. Enter zero if no claims occurred.

   Total Amount Paid on Medical Only Claims this Year: Enter the total amount paid on Medical Only claims paid this year for all dates of injury. Do not include any claims that have ever had any indemnity payments. Any medical claims that at one time had indemnity payments should be included under section C. Enter zero if no medical only claims were paid.

3. Section C

Total Amount of Income Benefits Paid on Indemnity Claims this Year: Enter the total amount of income benefits paid this year for all dates of injury. This will be the sum of three income benefits listed lower in Section C. Temporary Total + Temporary Partial + Permanent Partial = Total Amount of Income Benefits Paid.

Total Number of Indemnity Claims this Year: This will be the total of reported new indemnity claims that occurred during the reporting year. Enter zero if no new indemnity claims.

Total Amount of Temporary Total Benefits Paid this Year: Enter all TTD benefits paid on indemnity claims for the reporting year for all dates of injury. Include payments made pursuant to Liability Settlements and No-Liability Settlements as well as death claims. Enter zero when no TTD was paid. Permanent Total Disability (not recognized in Georgia) will be included here.

Total Amount of Temporary Partial Benefits Paid this Year: Enter all TPD benefits paid on indemnity claims in the reporting year for all dates of injury. Enter zero when no TPD was paid.

Total Amount of Permanent Partial Benefits Paid this Year: Enter all PPD benefits paid on indemnity claims in the reporting year for all dates of injury. Enter zero in no PPD was paid.

Total Medical Paid on Indemnity Claims this Year: Enter total medical benefits paid on indemnity claims in the reporting year for all dates of injury. Please do not include Hospital Payments. Prior indemnity claims that have settled the income benefits, but left the medical open, will be reported here. Enter zero when no medical was paid.

Total Hospital Payments on Indemnity Claims this Year: Enter total hospital benefits paid on indemnity claims in the reporting year for all dates on injury. Enter zero when no hospital benefits were paid.

*NOTE: If you are unable to separate Total Medical and Total Hospital Payments on Indemnity Claims, report on Total Medical Paid and explain in Total Hospital Payments box.

Report gross payouts not net payouts. Do not include recoveries, so no negative numbers.

Large Deductible Policies are to include all claims below the deductible in both Medical Only and Indemnity numbers.

D. Form WC-121 – Notice of Change of TPA (Third Party Administrator)/Servicing Agent

An insurer, self-Insurer, or Self-Insurance Group Fund shall file this form to provide notice of the employment of a claims office/TPA, change the address of a claims office/TPA, add

additional claims office/TPA, and provide notice of the termination of services of a claims office/TPA. A third party administrator/servicing agent must be licensed by the Office of the Commissioner of Insurance pursuant to O.C.G.A. §33-23-100.

*NOTE: Board Rule 121(f)(4) as referenced below for additional instructions when an insurer, self-insurer, or self-insurance group fund is changing from one claims office/TPA to another claims office/TPA.

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

(i) 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).

(ii) 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.

*NOTE: A WC-4 Case Progress Report must be filed with the Board within 90 days of receipt of an open case by the new claims office/TPA per Board Rule 61(5)(G).

E. Form WC-131 – Application for Permit to Write Insurance

Insurers will complete this form after receiving approval from the Georgia Office of Insurance and Safety Fire Commissioner Office, accompanied by current Georgia Certificate of Authority. Insurers will send Form WC-131 and Certificate of Authority to the Board to obtain a 5-digit SBWC ID number. Once the 5-digit SBWC ID number is obtained, the insurer may begin filing documents with the Board.

F. Form WC-131a – Annual Insurer Update

Insurers/self-insurers will complete this form annually (By June 1st) and file it with the Board to renew their permit to write workers' compensation policies in Georgia. Insurers/self-insurers are to include a current copy of their renewed Certificate of Authority from the Georgia Commissioner of Insurance with their submission. Insurers/self-insurers also complete this form whenever there is a change in their information.

G. EDI (Electronic Data Interchange) Forms

Additional information regarding EDI may be found on our website (sbwc.georgia.gov) or you may send an email to EDI@sbwc.ga.gov for assistance.

1. Vendors/Trading Partners must file an EDI Trading Partner Agreement and Application for EDI Partnership with the State Board.
2. Vendors/Trading Partners must file an EDI Trading Partner Profile (EDI Form 1) and EDI Trading Partner Insurer/Claims Administrator List (EDI Form 2) for each claims office for which they will be sending EDI filings.

* NOTE: See Board Rule 62 as referenced below for additional EDI filing.

(1)(b) 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 FROIs (First Reports of Injury) and SROIs (Subsequent Reports of Injury)."
(1)(e) When suspending benefits via EDI and an attachment to a filing or submission is required such as a medical report, WC-104 or WC-240, the employer, insurer, self-insurer, group self-insurer or designated claims office (TPA) shall mail to, or electronically file with the Board the required attachment prior to or simultaneously with the filing of the appropriate SROI suspension.

References: O.C.G.A. §33-23-100
§34-9-18(a)

Board Rules 61(5)(G), 62, 121, 126

# Chapter 6

## Electronic Data Interchange Filings (EDI)

The Board uses the IAIABC Claims Release 3 EDI standard for reporting workers' compensation claims. The Board requires reporting both the first reports of injury (FROI) and subsequent reports of injury (SROI) transactions to create a valid WC-1, Employer's First Report of Injury or Occupational Disease, with the exception of the denial of the claim in the first report.

FROI transactions complete the claim indentifying information in Section A of the WC-1. SROI payment transactions are required to complete the data in Sections B, C or D of the WC-1. After the claim is established in EDI, subsequent SROI transactions can be filed to report the data to complete the WC-2, WC-2a, WC-3 and WC-4.

Insurers, self-insured employers, Group Fund Insured employers and licensed third-party administrators can file EDI transactions to the Board through their own systems or by using the services of a Trading Partner who has registered with the Board with a valid Trading Partner Agreement which establishes the EDI reporting protocols.

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 after completing EDI testing. After successful testing, the Trading Partner shall not report EDI forms in paper.

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 FROIs (First Report of Injury) and SROIs (Subsequent Report of Injury).

3. All claims submitted by insurers, self-insurers, group self-insurers, and designated claims offices (TPAs) to the Board must be in EDI format.

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 is required, the forms shall be mailed to or electronically filed with the Board prior to or simultaneously with the filing of the EDI transaction.

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 terminate 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 7

## 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 5 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 5 percent per annum, may be accomplished by reducing the period of payment 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. If the application is by consent of all parties, indicate this on the form 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 applicable, 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 (form WC-25) 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 to schedule a mediation conference on the issues.

References: O.C.G.A. §34-9-222(a) (b)

Board Rules 61(b) (15), 222

# Chapter 8

## 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 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, should a physician on the panel of physicians refuse to provide treatment to an employee who has previously has received treatment from another panel physician, the employer/insurer, as soon as practicable, shall increase the panel for that employer by one physician for each such refusal.

Finally, 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. 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.

c. 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

If an emergency situation arises in which there is not time to comply with selection requirements, the injured employee is authorized to seek temporary care as may be necessary. This authorization lasts for the duration of the emergency. 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.

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.

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.

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 grounds 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 or CDT 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 or CDT 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 Current Dental Terminology (CDT©), CPT, DRG, or ICD-10 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.

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

Martha Turner-Quest, Executive Director
Georgia Psychological Association
13 Corporate Blvd, NE, Suite 220
Atlanta, GA 30329
(404) 634-6272, ext. 201; 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; FAX (404) 728-1975

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 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) (13) and Board Rule 200(f), 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 1500 Claim Form, UB 04 or American Dental Association (ADA) Dental Claim Form© 2012)

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) (13) and Rule 200(f).

F. Pre-Authorization of Medical Treatment

Form WC-205

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.

Form WC-PMT (Petition for Medical Treatment)

When an authorized treating provider has recommended medical treatment/testing and the employer/insurer have been provided documentation of such recommendation for at least 5 business days, but have failed to authorize the treatment/testing, the employee or the employee's attorney may file a petition (Form WC-PMT) to show cause why the medical treatment/testing that has been recommended should not be authorized. The Petition shall request the Board to issue a notice of a show cause telephonic conference before an

Administrative Law Judge to be scheduled for a date and time not more than 5 business days from the date of the Petition.

Upon the filing of Section B of the WC-PMT, the Board shall issue a Notice of Telephonic Conference for a date and time not more than 5 business days from the date of the Petition. The parties may participate, telephonically only, in the show cause conference by calling the telephone number listed on the Notice. The purpose of the telephonic conference will be to show cause why the treatment or testing at issue has not been authorized. Failure of any party to participate in the conference does not preclude a ruling on the Petition.

In lieu of participation in the telephonic conference, the employer/insurer may authorize the treatment by completing Section C of the WC-PMT or controvert the treatment by completing Section D of the WC-PMT. If the treatment is authorized, written notice of the authorization shall be provided to the medical provider. The completion and filing of the Controvert in Section D with proper service of the WC-PMT shall constitute notice that the compensability of the medical treatment/testing at issue is being controverted for the specific reasons stated. No additional filing of a Notice to Controvert for the requested medical testing/treatment shall be required.

Following the telephonic conference, an Administrative Law Judge may issue an Interlocutory Order which exclusively addresses authorization of the treatment or testing at issue. If it is determined that the treatment/testing should be authorized, the Order shall require the employer/insurer to provide written authorization to the medical provider. The Order will take effect absent timely objection.

Any party objecting to the Interlocutory Order may request a hearing within 20 days from the date of the Interlocutory Order. A Hearing Request will operate as a supersedeas of the order. Where treatment/testing has been ordered, the failure to request a hearing will be construed as consent to payment in accordance with the fee schedule for the requested medical treatment/testing.

G. Reimbursement of Group Insurance Company or Other Healthcare Provider

Form WC-206, including supporting documentation, shall be submitted to the Board during the pendency of the claim by the group insurance company or other healthcare provider 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 and approves 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 9

## 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 on the Board's website, www.sbwc.georgia.gov, under Publications.

# Chapter 10

## INSURER'S COVERAGE RESPONSIBILITIES

Upon an employer obtaining a policy for workers' compensation insurance, whether said insurance is obtained through the voluntary market or the involuntary market, the insurance company affording the coverage becomes responsible for all statutory coverage reporting requirements as well as statutory claims reporting upon notice of a claim by the employer.

A. 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 the 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 or insurers.

Jurisdiction of the insured, for the purposes of this chapter, shall be the jurisdiction of the insurer or insurers. The insurer or insurers shall in all things be bound by and subject to awards, judgements, or decrees rendered against such insured employer.

B. Insurer to Promptly Pay all Benefits (O.C.G.A. §34-9-124)

No policy or contract of insurance shall be issued unless it contains the agreement of the insurer that it will promptly pay all benefits conferred by this chapter and all installments of the compensation that may be awarded or agreed upon to the person entitled to them and that the obligation shall not be affected by any default of the insured after the injury or by any default in giving notice required by such policy or otherwise. Such agreement shall be construed to be a direct promise by the insurer to the person entitled to compensation and shall be enforceable in his name.

A policy of insurance issued under this chapter shall always first be construed as an agreement to pay compensation. An insurer who issues a policy of compensation insurance to an employer not subject to this chapter shall not plead as a defense that the employer is not subject to this chapter. An insurer who issues to an employer subject to this chapter a policy of compensation insurance covering an employee or employees ordinarily exempt from its provisions shall not plead the exemption as a defense. In either case, compensation shall be paid to an injured employee or to the dependents of a deceased employee for a compensable accident as if the employer of the employee or both were subject to this chapter, the policy of compensation insurance constituting a definite contract between all parties concerned.

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

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.

When an insurer, self-insurer, or group self-insurance fund obtains the services of a servicing agent or third-party administrator for the purpose of administering workers' compensation matters, the insurer, self-insurer, or group self-insurance fund shall give notice to the Board by the filing of Board Form WC-121. This form shall be used to provide notice of the employment of a servicing agent or third-party administrator, and of the termination of services of same. 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. This form shall also be used to add an additional third-party administrator.

A third-party administrator/servicing agent must be licensed by the Office of the Commissioner of Insurance pursuant to O.C.G.A. §33-23-100 and follow the Rules and Regulations of the Insurance Commissioner's Office.

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 Board 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.

D. Proof of Compliance with Insurance Provisions (Board Rule 126)

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 Board 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.

The Georgia State Board of Workers' Compensation's licensed rating organization is the:

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

E. Insurer Permit Requirement: Claim Office Within State (O.C.G.A §34-9-131)

Every insurance company and every person, firm or corporation writing policies of insurance under this chapter or insuring the payment of compensation to employees as provided by this chapter, before writing any such policy or entering upon any such insurance contract or continuing any such contract of force, shall obtain from the board a permit authorizing such company or such person, firm, or corporation to engage in business as an insurance carrier under this chapter and to write and enter upon such insurance contracts. Upon obtaining said permit, the insurer shall designate and maintain an office in the State of Georgia for the handling of claims or shall designate an agent located in the State of Georgia who shall be authorized to execute instruments for the payment of compensation.

F. Proration of Board's Expenses; Required Annual Reports and Statements; Audit of Board; Collection of Delinquent Assessments (O.C.G.A. §34-9-63)

a. The total expenses of the board shall be prorated among the qualified insurance companies writing compensation insurance in this state, hereinafter referred to as insurers, and employers subject to the provisions of this chapter whose workers' compensation insurance coverage is not written by these companies, hereinafter referred to as self-insurers, including, but not limited to, the state, counties, municipalities, and any political subdivisions or authorities thereof. Such proration shall be on the basis, in the case of the insurers, of the gross earned premium and, in the case of self-insurers, on the basis of the amount of premium which they would

have had to pay in the event they had insured their liability with an insurer; provided, however, the board may establish by rule a minimum assessment, based upon the administrative cost necessary to provide licensure support and basic computer management reports for each insurer or self-insurer, to be paid by insurers and self-insurers whose actual prorated assessment otherwise would be less than the minimum assessment. Prorated assessments based on the experience of the previous calendar year shall be made on July 1, based on the budget of the board for that fiscal year.

b. Sworn reports of the compensation premium writing of the insurers and sworn payroll statements of others for the preceding calendar year shall be filed with the board not later than March 1 of each year.

c. The books of the board shall be audited annually and a copy of such audit shall be available for inspection during normal business hours by all parties among whom the expenses of the board are prorated. All moneys assessed against insurers and others under this chapter shall be paid into the state treasury and held as a special fund solely for the operation of the board to administer this chapter.

d. The Attorney General shall enforce collection against insurers and others failing to comply with this Code section, based on reports of violation furnished by the board and investigation; the costs of collection shall be borne by the delinquent party.

e. Any insurer, private employer, or governing authority of a public employer that violates any provision of this Code section shall be guilty of a misdemeanor.

G. Subsequent Injury Trust Fund, Reports by Employers of Compensation and Benefits Paid; Failure to Pay Assessments (O.C.G.A. §34-9-359)

a. As soon as practicable after January 1 but not later than January 31 of each calendar year, the administrator shall forward to each insurer and self-insured employer a questionnaire asking for the total amount of compensation, medical benefits, and rehabilitation benefits paid by each insurer and self-insured employer during the preceding calendar year. This report is to be completed and returned to the administrator no later than March 1 of the same calendar year in which the request for this information is submitted. Failure to submit the report to the administrator of the fund by March 1 shall result in an automatic penalty of $50.00 per day for each day the report is delinquent or 10 percent of the assessment, whichever is greater. This penalty will be added to the assessment.

b. Any assessment levied or established in accordance with this article in a specified amount as may be determined pursuant to this article shall constitute a personal debt of every employer or insurer so assessed and shall be due and payable to the Subsequent Injury Trust Fund when payment is called for by the administrator. In the event of failure to pay any assessment upon the date determined by the

administrator, the administrator may file a complaint for collection against the employer or insurer in a court of competent jurisdiction.

c. In the event any employer or insurer duly assessed fails to pay to the administrator on behalf of the Subsequent Injury Trust Fund the amount so assessed on or before the date specified by the administrator, the administrator is authorized to add to the unpaid assessment an amount not exceeding 10 percent of the unpaid assessment and reasonable attorney's fees to defray the cost of enforcing collection.

H. Self-Insurer's Assessment of Participants; (O.C.G.A. §34-9-386)

1. The board of trustees shall, commencing January 1, 1991, assess each participant in accordance with paragraph (2) of this subsection. Upon reaching a funded level of $15 million net of all liabilities, all annual assessments against participants who have paid at least three prior assessments shall cease except as specifically provided in paragraph (4) of this subsection.

2. Assessment for each new participant in the first calendar year of participation shall be $8,000.00. Thereafter, assessments shall be in accordance with paragraphs (3) and (4) of this subsection.

3. After the first calendar year of participation, the annual assessment of each participant shall be made on the basis of a percentage of the total of indemnity and medical benefits paid by, or on behalf of, the participant during the previous calendar year. Except as provided in paragraph (2) of this subsection for the first calendar year of participation and paragraph (4) of this subsection, a participant will be assessed 1.5 percent of the medical and indemnity benefits paid by that participant during the previous calendar year or $2,000.00, whichever is greater. The maximum amount of annual assessments under this paragraph, not including those special assessments provided for in paragraph (4) of this subsection, in any calendar year against a participant shall be $8,000.00.

4. If the fund is reduced to an amount below $5 million net of all liabilities as the result of the payment of claims, the administration of claims, or the costs of administration of the fund, the board of trustees may levy a special assessment against participants upon approval by the board, according to the same procedure for assessment set forth in paragraph (3) of this subsection, in an amount sufficient to increase the funded level to $5 million net of all liabilities; provided, however, that such special assessment in any calendar year against any one participant shall not exceed $8,000.00.

I. Furnishing of Bond by Insurance Companies Doing Workers' Compensation Business in State; Bringing of Actions upon Bond; Posting of Security in lieu of Bond (O.C.G.A. §34-9-129)

Every insurance company doing a workers' compensation business in this state shall furnish a bond payable to the state in the sum of $50,000.00 with some surety company authorized to transact business in this state as surety, in such form as may be approved by the Commissioner of Insurance, conditioned for the payment of compensation losses on policies issued by such insurance company upon risks located in this state. An action may be brought upon said bond by the board for the use and benefit of any party or parties at interest. The annual license of such company shall not be issued or renewed until it has filed with the Commissioner of Insurance of this state the bond required by this Code section. In lieu of such bond, a deposit of the same amount may be made with the Office of the State Treasurer in the form of other security satisfactory to the Commissioner of Insurance.

J. Self-Insurance; Insurance by Counties and Municipalities; Application, Security, Excess (Board Rule 121)

a. Any employer desiring to become a self-insurer shall apply on the form prescribed by the Self-Insurers Guaranty Trust Fund Board of Trustees and approved by the Board. Such employer shall provide the Board with sufficient information for the Board to make an adequate assessment of the employer's workers 'compensation exposure and liabilities and shall further provide evidence satisfactory to the Board of such employer's financial ability to pay the compensation directly in the amount and manner when due, as provided in this chapter. All inquiries must be answered fully and will be treated as strictly confidential. The Self-Insurers Board of Trustees, with the approval of the Board, shall set the amount of security in the form of a surety bond or letter of credit to be required, but in no event shall the amount be less than $250,000.00. It shall be at the discretion of the Self-Insurers Guaranty Trust Fund Board of Trustees if other forms of security are acceptable. Each case will be considered on its own merits with strict regard to the hazards of the business involved. So long as an employer shall continue solvent and promptly pay any and all compensation legally due in accordance with the provision of the law there shall be no effort to collect under the securities.

b. *Excess insurance for self-insured governmental entities.* Counties, municipalities, and other political subdivisions must qualify as self-insurers or obtain insurance coverage. Permission for self-insurance by counties, municipalities and political subdivisions may be granted by application therefor and without deposit of surety bonds security. Assurance must be given the Board, however, that provision will be made for the payment of all workers' compensation benefits conferred by this chapter. Each active participant shall be required to purchase excess insurance in an amount and with specific retention levels acceptable to the Board.

K. Issuance of Board of Certificate of Self-Insurance; Review; Revocation (O.C.G.A. §34-9-127)

a. Whenever an employer has complied with those provisions of Code Section 34-9-121 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.

b. The board shall have the authority to review the self-insured status of an employer after a merger or acquisition involving the employer.

c. The board may, upon at least 30 days' notice to the employer, and proof of receipt of same, and after a hearing, revoke the certificate upon satisfactory evidence for such revocation having been presented. At any time after such revocation, the board may grant a new certificate to the employer upon the employer's petition.

L. Annual Reporting Requirements (O.C.G.A §34-9-63 and Board Rule 61)

Due March 1st:

1. Annual Premium Writing Report (Insurers)
2. Annual Report of Self-Insurer's Payroll (Self-Insurers)
3. Form WC-26. *Consolidated Yearly Report of Medical Only Claims and Annual Payments on Indemnity Claims.* File on or before March1st following each calendar year in respect to all medical and indemnity payments for the previous year for work-related injuries. File annually even if no reportable payment occurred during the reporting year.

Due June 1st:

1. Form WC-131(a). *Permit to Write Insurance Update.* Insurers shall complete this form annually and file it with the Board when updating a permit to write workers' compensation insurance in the state of Georgia. Include a copy of the current Certificate of Authority (COA) from the Georgia Office of Insurance and Fire Safety Commissioner with your submission.

For more information on Self-Insurance (not Governmental Self-Insurance), go to the Georgia Self-Insurers Guarantee Trust Fund website at:

https://www.gaguaranty.com/index.php/en/

References: O.C.G.A. §34-9-18(a)
§34-9-63
§34-9-123
§34-9-124

§34-9-127
§34-9-129
§34-9-131
§34-9-359
§34-9-386

Board Rules 61, 121, 126, 131

# Chapter 11

## 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. Ankyloses of major weight bearing joints
18. Hyperinsulinism
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 O.C.G.A. §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 had

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 or CDT) 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 or CDT) 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.

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