Georgia State Board of Workers' Compensation

Procedure Manual

Employer Reference Section

The Procedure Manuals are to be used as a 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.

July 2017

Table of Contents

CHAPTER 1

COVERAGE

CHAPTER 2

REPORTING REQUIREMENTS FOR EMPLOYERS
(CLAIMS FORMS (BOARD RULE 61)

CHAPTER 3

METHOD OF PROVIDING MEDICAL TREATMENT

CHAPTER 4

MEDICAL

CHAPTER 5

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

CHAPTER 6

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

CHAPTER 7

REHABILITATION

Chapter 1

COVERAGE

A. Employer's Duty to Insure Payment of Compensation

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

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

Pursuant to O.C.G.A. §34-9-121(b)(1) "Any employer from another state engaged in the construction industry within this state with a workers' compensation policy issued under the laws of such other state so as to cover that employer's employees while in this state shall be in compliance with subsection (a) of this Code if:

(A) Such other state recognizes the extraterritorial provisions of O.C.G.A. §34-9-242; and
(B) Such other state recognizes and gives effect within such state to workers' compensation policies issued to employers of this state."

B. Self-Insurance (O.C.G.A. §34-9-127 and §34-9-380 et seq and Board Rule 121)

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

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 to the Board, on a form entitled Confidential Application for Governmental Self-Insuring Employers and without deposit of surety bonds. Assurance must be given the Board that provision will be made for payment of all workers' compensation liabilities. Each active participant shall be required to purchase excess insurance in an amount and with specific retention levels acceptable to the Board.

Whenever an employer has complied with the provisions of the Workers' Compensation Act relating to self-insurance, the Board shall issue to such employer a certificate which shall remain in force for a period fixed by the Board; but the Board may, upon at least 30 days' notice to the employer and after a hearing, revoke the certificate upon satisfactory evidence for such revocation having been presented.

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

C. Group Self-Insurers (O.C.G.A. §34-9-150 and Board Rule 126(b))

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

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

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

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

3. If the self-insured member employer operates under different trade names or d/b/a ("doing business as"), a separate Form WC-11 must be filed for each trade name, properly cross-referenced.

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

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

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

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

Every employer insured by a licensed insurer shall have proof of coverage documented by its insurer directly with a Licensed Rating Organization through their policy information system. Every employee leasing company shall have proof of coverage documented with a Licensed Rating Organization of the initiation or termination of any contractual relationship with a client company; for the purposes of this Rule, the term employee leasing company shall refer to both: (1) any employee leasing company as defined in O.C.G.A. 34-8-32; and (2) any professional employer organization (PEO) 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.

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

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

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

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

Whenever any employee whose injury or death is compensable under this Chapter shall at the time of the injury be in the joint service of two or more employers subject to this chapter, such

employers shall contribute to the payment of such compensation in proportion to their wage liability to such employee.

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

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

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

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

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

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

   e. The total compensation payable under this section to a surviving spouse as a sole dependent at the time of death and where there is no other dependent for one year or less after the death of the employee shall in no case exceed $230,000.

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

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

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

   Occupational disease is defined as those diseases, which arise out of and in the course of the particular employment in which the employee is exposed to such disease, provided that the employee proves all of the following:

   a. A direct causal connection between the conditions under which the work is performed and the disease;

   b. That the disease followed as a natural incident of exposure by reason of the employment;

   c. That the disease is not of a character to which the employee may have had substantial exposure outside of the employment;

   d. That the disease is not an ordinary disease of life to which the general public is exposed; and

   e. That the disease must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a natural consequence.

   Partial loss of hearing due to noise shall not be considered an occupational disease. Psychiatric and psychological problems and heart and vascular diseases shall not be considered occupational diseases, except where they arise from a separate occupational disease.

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

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

   b. The claim for disablement is filed within one year after the date the employee knew or, in the exercise of reasonable diligence, should have known of the disablement and its relationship to the employment; but in no event shall the claim for disablement be filed in excess of seven years after the last injurious exposure to the hazard of such disease

in such employment. In cases of death where the cause of action was not barred during the employee's life, the claim must be filed within one year of the date of death.

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

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

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

3. 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.

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

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

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

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

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

Chapter 2

REPORTING REQUIREMENTS FOR EMPLOYERS
CLAIMS FORMS (BOARD RULE 61)

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

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

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

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

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

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

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

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

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

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

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

7. Form WC-20(a) Medical Report (may also 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 employer/insurer as follows:

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

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

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

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

8. Medical Reports

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

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

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

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

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

Chapter 3

METHOD OF PROVIDING MEDICAL TREATMENT

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

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

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

   a. The employer shall maintain a list of at least six physicians or professional associations or corporations of physicians who are reasonably accessible to employees. This list shall be known as the P-1 "Panel of Physicians Poster" and is also available in Spanish. The employee may make one change from one physician to another on the same panel without prior authorization from the Board.

      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. However, should a physician on the panel of physicians refuse to provide treatment to an employee who has previously 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.

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

   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 of the Board. The physician so selected will become the primary treating physician in control of the employee's medical care.

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

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

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

4. If an emergency situation arises in which there is not time to comply with selection requirements, the injured employee is authorized to seek temporary care as 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.

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

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

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

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

B. Changes in Treatment

Except as provided in Subsection (b) of O.C.G.A. §34-9-201, changes in physician or treatments are made only by agreement of the parties or by order of the Board. Board authorized changes are effective on the date the request is filed with the Board, unless a later date is specified in the Board's order. The request for change in physician shall include the address of the physician to whom a change or additional treatment is desired. A request for, or objection to, a change of

physician or additional treatment must be filed on Form WC-200b, with supporting documentation attached and with copies provided to all parties. If the argument in support of, or in objection to, the change is based on testimony, an affidavit must be attached to the form and, if the argument refers to documents, a copy of the documents must be attached. Parties are required to make a "good faith" effort to resolve a change of physician dispute prior to filing a Form WC-200b.

Chapter 4

MEDICAL

A. Medical Reports (Board Rule 200 (e)

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

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

The employer/insurer shall maintain copies of all medical reports and attachments in their files and shall not file medical reports with the Board except in compliance with Board Rules 61(b)(13).

The employee shall, upon the request of the employer/insurer, furnish copies of all medical records and reports in his/her possession within 30 days of the date of the request, the cost of which shall be charged to the employer/insurer according to the fee schedule. The employer/insurer shall, upon the request of the employee, furnish copies of all medical reports in their possession within 30 days of the date of the request, at no expense to employee. Upon failure of either party to furnish information as provided above, the physician or other medical providers shall, upon request, furnish copies of all medical reports and bills in their possession at no expense to the employee, the cost of such records shall be billed according to the fee schedule, and charged against the party determined to be responsible for payment of medical expenses (Board Rule 61(b)(18); Board Rule 200 (f)).

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

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

2. The employer/insurer shall give the employee and/or his/her attorney ten (10) days written notice of the time and place of any requested examination. Advance payment of required travel expenses shall accompany such notice.

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

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

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. The insurer/self-insurer must provide written notification to the medical provider within 30 days of the receipt of medical charges, the reasons for non-payment of medical expenses and a written itemization of any documents or other information needed to process the claim for medical benefits. Failure of the insurer/self-insurer to notify the medical provider in writing within 30 days of the receipt of the charges of the need for further documentation will be deemed a waiver of the right to defend a claim for failure to pay charges in a timely fashion on the ground that the charges were not accompanied with the proper documentation. However, this waiver does not extend to any other defense the insurer/self-insurer may have with respect to a claim of untimely payment. If the insurer/self-insurer is controverting the medical expenses, they must file a Form WC-3, Notice to Controvert, with the Board within the 30 days allowed for payment. All persons having a financial interest, including the physician, must receive a copy of the Form WC-3.

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

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

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

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

Medical expenses shall be limited to the usual, customary and reasonable charges. Employers/insurers may automatically conform charges according to the fee schedule adopted by the Board, and the charges listed in the fee schedule shall be presumed usual, customary and reasonable and shall be paid within 30 days from the date of receipt of the charges. Employer/insurer shall not unilaterally change any CPT-4 or CDT code of the provider. All charges 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 Benefit code used.

Any health service provider whose fee is reduced to conform to the fee schedule may request peer review of charges and present evidence as to the reasonableness of his/her charges. If the dispute is not resolved through the recommendations of peer review, then mediation or hearing may be requested. An employer/insurer who disputes that any charge as the usual, customary and reasonable charge prevailing in the state of Georgia shall, within 30 days of the receipt of the charges, file with the appropriate peer review committee a request for review of only those specific charges which are disputed. No CPT, CDT, 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
Tucker, 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 evidence of the usual, customary and reasonable charges.

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

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

Chapter 5

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

(Workers' Compensation Fraud)

A. Enforcement Division

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

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

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

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

B. Authority to Inspect

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

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

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

C. Compliance with Insurance Requirements

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

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

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

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

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

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

O.C.G.A. §34-9-18(b) provides a civil penalty of not less than $1,000.00 nor more than $10, 000 per violation when any person knowingly and intentionally makes any false or misleading statement or misrepresentation for the purpose of obtaining or denying workers' compensation benefits or payments. O.C.G.A. §34-9-19 provides criminal sanctions against any person, firm, or corporation who willfully makes false or misleading statements or representations for obtaining or denying workers' compensation benefits or payments. Upon conviction, a fine of not less than $1,000 or more than $10,000 or by imprisonment not to exceed 12 months or both may be levied.

F. Penalty for Employee's Fraudulent Receipt of Benefits

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

G. Payment of Penalties

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

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

Chapter 6

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

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

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

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

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

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

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

Chapter 7

REHABILITATION

A. Reference to Insurer/Self-Insurer Section

This chapter of the Procedure Manual is 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.