HOME STUDY MATERIALS

WORKERS' COMPENSATION SEMINAR 2024

These materials are designed for home study. The Georgia Workers' Compensation Act should also be used as a reference.

A proctored examination will be given at the close of the May 15, 2024 seminar at Villa Christina.

Study and examination will provide 9.0 CEU hours.

Workers' Compensation 2022–2023: Panels, Pandemic, Premiums, and Partnerships

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I. Legislation

The survey period featured limited legislation.[1] House Bill 480[2] increased the maximum rate of temporary total disability benefits from $725 to $800 and increased the maximum rate of temporary partial

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[1] For an analysis of worker's compensation law during the prior survey period, *see* H. Michael Bagley & J. Benson Ward, *Workers' Compensation, Annual Survey of Georgia Law,* 74 MERCER L. REV. 299 (2022).

[2] Ga. H.R. Bill 480, Reg. Sess. 2023 Ga. Laws 416.

disability benefits from $483 to $533.[3] Similarly, the maximum amount of death benefits payable to a sole surviving spouse was increased from $290,000 to $320,000.[4]

The requirements for recovery of dependency benefits ensuing from a deceased employee have long been addressed in two separate statutes: O.C.G.A. § 34-9-13[5] and O.C.G.A. § 34-9-265.[6] The bill revised the dependency provisions of § 34-9-13, addressing cohabitation where the alleged dependent is neither a spouse nor child of the deceased employee.[7] The amendments to § 34-9-13 remove all references to gender and sex, while shifting the focus of the dependency analysis to "evidence proving the deceased employee provided support of economic value to the claimant dependent, including, but not limited to, monetary support, sustenance, or housing."[8] Section 34-9-13(d) now provides that there is no presumption of

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[3] *Id.* §§ 2–3.

[4] *Id.* § 4.

[5] O.C.G.A. § 34-9-13 (2023).

[6] O.C.G.A. § 34-9-265 (2023).

[7] O.C.G.A. § 34-19-13; Ga. H.R. Bill 480 § 1.

[8] O.C.G.A. § 34-9-13(d) (2023).

dependency for a non-spouse, even if the non-spouse lived with the deceased employee in a relationship analogous to a marriage, and it will be the claimant's burden to prove financial support.[9] Retained in § 34-9-13(d) is the requirement that "no allowance shall be made for any payment made exclusively in lieu of board and lodging or services."[10] The same requirement is added to § 34-9-13(e)[11] addressing suspension of a surviving spouse's dependency benefits, which also no longer references a "meretricious relationship," nor requires proof of cohabitation including sexual intercourse or the sharing of living expenses.[12] There was no modification of § 34-9-265(c),[13] which requires that dependency benefits "shall be payable only to dependents and only during dependency."[14]

II. Panel of Physicians

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[9] *Id.*

[10] O.C.G.A. § 34-9-13(d) (2000).

[11] O.C.G.A. § 34-9-13(e) (2023).

[12] *Id.*; *see* O.C.G.A. § 34-9-13(e) (2000).

[13] O.C.G.A. § 34-9-265(c) (2023).

[14] *Id.*; Ga. H.R. Bill 480 § 1(e).

In *Lilienthal v. JLK, Inc.*,[15] the Court of Appeals of Georgia addressed the proper posting of the panel of physicians.[16] The claimant worked as a preschool teacher for the employer for more than three years when she had a slip and fall injury. When she requested medical treatment, the employer provided her with a copy of the panel of physicians and scheduled an appointment for the claimant at an orthopedist's office that was closest to her home. The claimant testified that she did not know she could select a provider or decline the panel provider chosen for her by the employer, but at any rate, the claimant was treated by this orthopedist for more than half a year. The claimant continued to work, and because of continued knee pain she obtained an independent evaluation with an off-panel physician, who suggested that she was a candidate for surgery.[17] The claimant then sought a change of physician to this off-panel provider, arguing that she was entitled to select any doctor of her choosing because the employer

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[15] 367 Ga. App. 721, 888 S.E.2d 310 (2023).

[16] *Id.* at 721, 888 S.E.2d at 311.

[17] *Id.* at 722, 888 S.E.2d at 311–12.

failed to post a copy of the panel of physicians in "prominent places upon the business premises" as required by O.C.G.A. § 34-9-201(c).[18]

In evaluating the employer's compliance with the statute's requirements, the court noted that the claimant signed an acknowledgment form during new hire orientation.[19] The acknowledgment form stated the location and function of the panel of physicians, though apparently the language in the form was unclear. The claimant testified that she never received a new hire orientation showing her the physical location of the panel of physicians or explaining its purpose. The panel of physicians was posted inside the preschool's Resource Room, an art supply closet in the school's main corridor. The school's policy required the single door to the Resource Room to remain locked when not in use because some equipment stored in the room could be harmful to a child, and the sole key to the Resource Room was located in a metal box inside a closed desk drawer used by the school's administration. The upper half of the door to the Resource Room had a glass window panel, and there was contradictory testimony at the hearing as to whether the lights in the Resource Room were typically

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[18] *Id.* at 723, 888 S.E.2d at 312; O.C.G.A. § 34-9-201(c) (2015).

[19] *Lilienthal*, 367 Ga. App. at 722–23, 888 S.E.2d at 312.

left on or off. The claimant testified that she rarely used the Resource Room because it did not contain supplies or materials that she needed for her classroom.[20]

The Administrative Law Judge (ALJ) found that the claimant had access to the Resource Room even if she did not enter the room often, and the room being locked did not preclude her access.[21] The ALJ concluded that "the fact that the panel was not in a better place does not mean that the place it was located was inadequate," finding that the posting of the panel in the Resource Room was sufficient to satisfy § 34-9-201.[22] Accordingly, the ALJ denied the claimant's request to treat with a non-panel physician.[23] The State Board of Workers' Compensation's Appellate Division affirmed, as did the Gwinett County Superior Court.[24]

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[20] *Id.* at 723, 888 S.E.2d at 312.

[21] *Id.* at 723, 888 S.E.2d at 312–13.

[22] *Id.* at 723–24, 888 S.E.2d at 313; O.C.G.A. § 34-9-201 (2015).

[23] *Lilienthal*, 367 Ga. App. at 724, 888 S.E.2d at 313.

[24] *Id.*

The issue before the court of appeals was whether the panel was posted in a prominent place upon the business premises.[25] Noting that the phrase "prominent places" is not defined in the Workers' Compensation Act,[26] the court consulted the dictionary definition of "prominent," which means "standing out or projecting beyond a surface or line, readily noticable; conspicuous,' 'immediately noticable' and 'situated so as to catch the attention; noticable."[27] The court held that the ALJ only evaluated that the panel of physicians was accessible but did not make a finding as to whether the panel of physicians posted in the Resource Room was in a "prominent or conspicuous place."[28] Based on this analysis, the court reversed and remanded the decision.[29]

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[25] *Id.* at 725, 888 S.E.2d at 313.

[26] O.C.G.A. tit. 34, ch. 9 (1978).

[27] *Lilienthal*, 367 Ga. App. at 725, 888 S.E.2d at 314 (footnotes omitted) (first quoting MERRIAM WEBSTER'S COLLEGIATE DICTIONARY 994 (11th ed. 2003); then quoting THE AMERICAN HERITAGE DICTIONARY 1410–11 (5th ed. 2018); and then NEW OXFORD AMERICAN DICTIONARY 1397 (3d ed. 2010)).

[28] *Id.* at 725, 888 S.E.2d at 314 (punctuation omitted).

[29] *Id.* at 726, 888 S.E.2d at 314.

III. Tolling Statutes of Limitations for COVID

The case of *Coastal Home Care v. Fann-Roberts*[30] addressed the procedural impact of tolling during the COVID-19 pandemic on a claim that was initiated more than three years before the start of the pandemic.[31] The claimant filed a workers' compensation claim for benefits, alleging an on-the-job injury on July 20, 2016, and the employer denied the claim.[32] While the claimant requested multiple hearings before the State Board, each hearing was ultimately removed from the calendar and did not go forward. The claimant filed her last hearing request on August 10, 2021, and subsequently an ALJ granted the employer's motion to dismiss on the grounds that more than five years had passed from the date of injury with no hearing having been held, pursuant to O.C.G.A. § 34-9-100(d)(1).[33] In so ruling, the ALJ rejected the claimant's argument that this five-year time period was tolled by the Orders issued by the Chief Justice of the Supreme Court of Georgia Declaring a Statewide Judicial Emergency in response to

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[30] 367 Ga. App. 779, 888 S.E.2d 621 (2023).

[31] *Id.* at 782, 888 S.E.2d at 624.

[32] *Id.* at 779, 888 S.E.2d at 622.

[33] *Id.* at 779–80, 888 S.E.2d at 622; O.C.G.A. § 34-9-100(d)(1) (2007).

the COVID-19 pandemic, on the grounds that those orders did not specifically extend statutes of repose, and further that the Chief Justice's June 12, 2020 order specified that normal deadlines applied to cases filed after July 14, 2020, and the claimant's hearing request was filed in 2021.[34]

The Appellate Division adopted the ALJ's decision, but the superior court reversed.[35] The superior court found that it was unclear whether § 34-9-100(d)(1) "fell into either the definition of a statute of limitation or a statute of repose" and concluded that the provision "was more closely analogous to a rule of procedure that could be tolled under certain circumstances."[36] The superior court found that the expansive language of the Chief Justice's Orders encompassed the five-year time limit, and because the claimant's claim was pending prior to March 14, 2020, she had an additional 122 days beyond July 20, 2021 (to November 19, 2021), to bring her claim to a hearing.[37]

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[34] *Coastal Home Care*, 367 Ga. App. at 780, 888 S.E.2d at 622.

[35] *Id.*

[36] *Id.*; O.C.G.A. § 34-9-100(d)(1).

[37] *Coastal Home Care*, 367 Ga. App. at 780, 888 S.E.2d at 622.

On appeal, the Court of Appeals of Georgia agreed with the superior court that § 34-9-100(d)(1) does not fall into the category of either a statute of repose or a statute of limitations, as the statute involves the dismissal of claims that have already been filed.[38] However, the court concluded that it was not required to determine whether § 34-9-100(d)(1) is a statute of limitation, a statute of repose, or something else altogether because the expansive language in the Chief Justice's order covers "any deadlines or other time schedules and is not limited to the enumerated examples."[39] Therefore, "under the plain language of the Chief Justice's Orders, the five-year time period to hold a hearing was tolled for the 122 days between March 14 and July 14, 2020."[40] The court also found unpersuasive the employer's arguments that the claimant's claim was not pending as of March 14, 2020, because no hearing was on the calendar.[41]

IV. Joint Venture

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[38] *Id.* at 782, 888 S.E.2d at 623.

[39] *Id.* (punctuation omitted).

[40] *Id.* at 782, 888 S.E.2d at 624.

[41] *Id.* at 783, 888 S.E.2d at 624.

The case of *Rogers v. HHRM Self-Perform, LLC*[42] involved the death of Sonny Rogers while working for his employer, Sunshine Forming, Inc., on the construction of Mercedes-Benz Stadium.[43] The employer had subcontracted with a joint venture (HHRM Self-Perform, LLC) to perform concrete work on the stadium. The decedent's sister, as administrator of his estate, brought a tort suit against the individual members of the joint venture along with other entities involved in the project and individuals employed by the entities including a district manager, safety manager, project foreman, safety director, and senior safety coordinator.[44]

The Fulton County State Court granted summary judgment as to Skyline and HHRM on the grounds that they were the statutory employers of Rogers because they were both secondarily liable for workers' compensation benefits in the event that Rogers was unable to recover from his immediate employer, Sunshine.[45] The trial court granted the motion for judgment on the pleadings as to the other defendants, including the

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[42] 365 Ga. App. 862, 880 S.E.2d 351 (2022).

[43] *Id.* at 862, 880 S.E.2d at 353.

[44] *Id.*

[45] *Id.* at 865, 880 S.E.2d at 355.

individual members of the joint venture, ruling that under O.C.G.A. § 34-9-11,[46] "every joint venturer is responsible for the workers[']compensation benefits of each employee of another joint venturer [where] that employee is engaged in the activities of the joint venture."[47]

The trial court granted summary judgment in favor of safety officers for one of the members of the joint venture, as there was no evidence that these safety officers committed affirmative acts directed toward the deceased employee or had direct involvement in implementing safety practices at the construction site that increased the risk of injury.[48] Finally, the trial court granted summary judgment to individuals employed by Sunshine, on the grounds that they were immune from tort suit as employees of the same employer as the deceased employee.[49] On appeal, the plaintiff argued that the Act's exclusive remedy provision extends only

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[46] O.C.G.A. § 34-9-11 (2015).

[47] *Rogers*, 365 Ga. App. at 865, 880 S.E.2d at 355; O.C.G.A. § 34-9-11.

[48] *Rogers*, 365 Ga. App. at 865–66, 880 S.E.2d at 355–56.

[49] *Id.* at 865–66, 880 S.E.2d at 355.

to the joint venture itself but not to the individual members nor certain employees performing safety or supervisory roles.[50]

The Court of Appeals of Georgia first addressed the joint venture, holding that individual joint venture members shared in the immunity afforded by the Act's exclusive remedy provision, § 34-9-11(a),[51] because they shared in the obligation to provide workers' compensation benefits.[52] In cases involving claims by employees against employers, an employee engaged in the work of the joint venture is an employee of each of the joint venturers, and therefore workers' compensation laws are the exclusive remedy of the employees against those individual partners or joint venturers.[53] Turning to the plaintiff's argument that tort liability may only be conferred upon the legally existing partnership itself, rather than upon the individual members of the partnership, the court held that because the deceased employee was engaged in the business of the joint venture at the

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[50] *Id.* at 866, 880 S.E.2d at 355–56.

[51] O.C.G.A. § 34-9-11(a) (2015).

[52] *Rogers*, 365 Ga. App. at 869, 880 S.E.2d at 358.

[53] *Id.* at 867–68, 880 S.E.2d at 356–57 (citing Boatman v. George Hyman Constr. Co., 157 Ga. App. 120, 123–24, 276 S.E.2d 272, 275 (1981)).

time he was injured, the distinction between a partnership and a joint venture was of no consequence.[54]

The court next addressed the judgment in favor of the safety officers.[55] Because these individuals were employees of a member of the joint venture, which was considered a statutory employer under O.C.G.A. § 34-9-8(a),[56] the court held that the plaintiff was required to demonstrate a triable issue of fact that either the safety officer committed an affirmative act causing or increasing the risk of injury to another employee, and the lack of such evidence justified summary judgment to the two individuals.[57] The court of appeals also upheld the grants of summary judgment in favor of the district manager, safety manager, and project foreman.[58] There was no evidence that the individuals assumed a general duty of care toward the deceased employee by engaging in activities wholly separate from the statutory employer-employee relationship, so the court declined to hold

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[54] *Id.* at 869, 880 S.E.2d at 358.

[55] *Id.*

[56] O.C.G.A. § 34-9-8(a) (1969).

[57] *Rogers*, 365 Ga. App. at 871, 880 S.E.2d at 359.

[58] *Id.* at 871–72, 880 S.E.2d at 359–60.

that those defendants' acts of creating and implementing general construction practices fall within the narrow affirmative acts exception to a supervisory employee's immunity.[59]

V. Subrogation

In *Donegal Mutual Insurance Group v. Jarrett*,[60] the Court of Appeals of Georgia upheld a summary judgment ruling against a workers' compensation insurer attempting to enforce a subrogation lien on the injured worker's third-party tort action.[61] The claimant incurred an on-the-job injury and received workers' compensation benefits, and he also brought an action for negligence against a third-party tortfeasor in which he sought economic and noneconomic relief. The tort action settled for approximately four times the amount of workers' compensation benefits paid to the claimant under his workers' compensation claim.[62]

The workers' compensation insurer brought an action to enforce its subrogation lien on the claimant's tort settlement, and the claimant moved

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[59] *Id.* at 873, 880 S.E.2d at 360.

[60] 364 Ga. App. 506, 875 S.E.2d 496 (2022).

[61] *Id.* at 506, 875 S.E.2d at 497.

[62] *Id.* at 506–07, 875 S.E.2d at 497.

for summary judgment on grounds that the workers' compensation insurer cannot recover its subrogation lien because the claimant has not been made whole or fully compensated.[63] Notwithstanding the workers' compensation insurer's argument that a genuine issue of material fact existed on the claimant having been made whole—with reference made to disputes over the claimant's current physical condition, daily activities, and future prognosis—the trial court granted the motion for summary judgment.[64]

On appeal, the court observed that subrogation under the Workers' Compensation Act is governed by O.C.G.A. § 34-9-11.1,[65] which provides that recovery is conditioned upon the claimant having been "fully and completely compensated."[66] The court cited Georgia caselaw holding that subrogation liens are available only against recovery for economic losses, and are unenforceable with respect to noneconomic losses such as pain and

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[63] *Id.* at 507, 875 S.E.2d at 497–98.

[64] *Id.* at 507, 875 S.E.2d at 498.

[65] O.C.G.A. § 34-9-11.1 (1995).

[66] *Donegal Mut. Ins. Grp.*, 364 Ga. App. at 508, 875 S.E.2d at 498 (quoting O.C.G.A. § 34-9-11.1).

suffering.[67] In order for a workers' compensation insurer to meet its burden of proof to enforce a subrogation lien, it must prove the injured worker was fully and completely compensated as to each category of noneconomic loss for which the insurer seeks subrogation, and that no portion of the subrogation lien is taken against recovery for noneconomic losses.[68] The trial court must find what portion of the claimant's recovery against the third party was intended to compensate him for his economic losses versus his noneconomic losses—and if such a determination cannot be made, then under *Best Buy Co., Inc. v. McKinney*,[69] the court cannot enforce the subrogation lien.[70]

The lump sum settlement entered into between the injured worker and the third-party tortfeasor precluded the trial court from finding what portion of the settlement was allocated to economic losses and what portion

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[67] *Id.* at 509, 875 S.E.2d at 498.

[68] *Id.* at 509, 875 S.E.2d at 498–99 (citing Endsley v. Geotechnical & Env't Consultants, Inc., 339 Ga. App. 663, 672, 794 S.E.2d 174, 181 (2016)).

[69] Best Buy Co. Inc. v. Mckinney, 334 Ga. App. 42, 778 S.E.2d 51 (2015).

[70] *Donegal Mut. Ins. Group*, 364 Ga. App. at 509, 875 S.E.2d at 499 (citing *Best Buy Co. Inc.*, 334 Ga. App. at 45, 778 S.E.2d at 54).

was allocated for noneconomic losses.[71] The court of appeals held that the workers' compensation insurer did not present evidence that would help the trial court find the amount that would constitute a full and complete recovery by the injured worker.[72] The court reasoned that neither the amount of the settlement compared to the amount of workers' compensation benefits received nor questions of fact regarding the claimant's need for future medical treatment were sufficient for the trial court to conclude that the claimant was fully and completely compensated, where there was no mention of allocation between economic and noneconomic consideration, particularly in light of the language in the settlement release denying that the settlement fully compensated the claimant.[73] Accordingly, the court of appeals affirmed the grant of summary judgment to the injured worker.[74]

VI. Setting Aside a Settlement

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[71] *Id.*

[72] *Id.* at 510, 875 S.E.2d at 499.

[73] *Id.* at 509–11, 875 S.E.2d at 499–500.

[74] *Id.* at 511, 875 S.E.2d at 500.

The case of *Smith v. Parks Hotels & Resorts, Inc.*[75] involved disputes among the conservators in probate court long after the underlying workers' compensation claim settled.[76] The deceased employee in *Smith* worked as a housekeeper at a Hilton hotel, and while at work, she was shot and killed by her boyfriend. The deceased employee's aunt was appointed by the probate court to be the permanent legal guardian of four of the deceased employee's children, and the temporary guardian of her other child, and the aunt brought a workers' compensation death claim on behalf of the children, in her capacity as guardian. The probate court subsequently appointed the aunt as conservator of all five children of the deceased employee. At a State Board of Workers' Compensation mediation, the conservator reached a settlement with the employer. The parties entered into a settlement agreement in which the employer denied liability for the death.[77]

The probate court appointed an administrator of the deceased employee's estate, authorizing her to receive the settlement funds.[78] The

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[75] 364 Ga. App. 192, 874 S.E.2d 383 (2022).

[76] *Id.* at 192, 874 S.E.2d at 384.

[77] *Id.* at 193–94, 874 S.E.2d at 384–85.

[78] *Id.* at 194, 874 S.E.2d at 385.

employer sent a revised settlement agreement providing that the funds owed to the deceased employee's children would be paid to the administrator of the estate. The administrator agreed to this revision and the conservator signed the stipulation and agreement, which was approved by the State Board. The following year, the administrator petitioned to remove the conservator on grounds that the conservator had not posted the bond necessary to receive the settlement proceeds, and eventually an agreement was achieved for a replacement conservator. The new-replacement conservator filed a motion in the trial court to set aside the workers' compensation settlement, arguing that it was void because there was a non-amendable defect on the face of the record and the State Board approval was the result of fraud, accident, or mistake. The trial court denied the motion, and the Court of Appeals of Georgia granted a discretionary appeal.[79]

In evaluating whether a judgment should be set aside under O.C.G.A. § 9-11-60(d)(3),[80] the court noted that it must first determine whether any evidence supported the trial court's finding that a defect actually existed,

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[79] *Id.* at 194–195, 874 S.E.2d at 385–86.

[80] O.C.G.A. § 9-11-60(d)(3) (1987).

amendable or otherwise.[81] The court of appeals found no evidence to support the trial court's factual finding that the probate court required written approval of the settlement and so determined that the trial court abused its discretion in finding a defect on the face of the record, but the trial court's denial of the motion to set aside settlement was affirmed as right for any reason.[82]

VII. Insurance Premiums

In *Buford Drywall, Inc. v. American Zurich Ins. Co.*,[83] the insurer brought suit against the employer for payment of past-due insurance premiums.[84] The employer failed to file an answer, and the insurer moved for default judgment. In its motion, the insurer noted that damages were not liquidated and entered proof as to the amount of unpaid premiums. One day after the insurer filed its motion, and without holding a trial on

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[81] *Smith*, 364 Ga. App. at 196–97, 874 S.E.2d at 387.

[82] *Id.* at 198–99, 874 S.E.2d. at 388.

[83] No. A22A1576 (Ga. App. Nov. 29, 2022).

[84] *Id.* at 1.

damages, the trial court entered default judgment for the insurer in the amount of unpaid premiums requested plus interest and costs.[85]

The employer appealed, arguing that the trial court erred in entering default judgment without conducting a hearing or giving the employer an opportunity to respond.[86] The court of appeals cited O.C.G.A. § 9-11-55(a)[87] for the proposition that, when damages are unliquidated, a trial court presented with a motion for default judgment ordinarily must conduct an evidentiary hearing on damages.[88] Accordingly, the court vacated the trial court's entry of default judgment and remanded for a hearing to establish the amount of damages.[89]

The case of *LM Insurance Corporation v. London*[90] similarly dealt with a workers' compensation insurer bringing suit against its customer for

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[85] *Id.* at 1–2.

[86] *Id.* at 2.

[87] O.C.G.A. § 9-11-55(a) (1982).

[88] *Buford Drywall, Inc.*, No. A22A1576 at 3.

[89] *Id.* at 4.

[90] 367 Ga. App. 783, 888 S.E.2d 580 (2023).

payment of insurance premiums.[91] The defendant employer in *London* was a sole proprietor of a painting company that was required to carry workers' compensation insurance for one of its job sites. In 2018, he applied for and obtained an assigned risk policy to cover painting services, with an estimated annual premium of $1,500, and per the terms of the policy, the final premium amount would be determined by an audit at the end of the policy term. In 2020, the insurer conducted an audit to determine the actual premium amounts for both policies and, although the employer originally listed no employees or subcontractors on his insurance plan, he told the auditor that he had more business than expected and so had relied on subcontractors to perform some work. The auditor added classifications for drywall and janitorial services to the policy, which caused the premium to increase from the estimated amount, and the auditor notified the employer that he owed a total of $22,275 on two policies.[92]

The employer did not pay the increased premium, and the insurer filed suit and served the employer with requests to admit, wherein he was asked to admit that he received workers' compensation coverage, made no

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[91] *Id.* at 784, 888 S.E.2d at 581.

[92] *Id.*

payments on the amounts due, and owed the unpaid balance.[93] The employer answered the complaint but did not respond to the requests to admit. At a bench trial, the court found in favor of the employer, finding that he had provided documentation showing he paid subcontractors to do work differently from the type of work that he performed and was not required to provide workers' compensation coverage for those independent contractors. The trial court found that the auditor should not have considered the independent contractor jobs in the recalculation, and thus, the adjusted premium was invalid.[94]

On appeal, the court agreed with the insurer that—because the employer did not respond to any requests to admit, did not seek withdraw or amend his admissions, and did not offer any explanation for his failure to respond, such that the trial court could have exercised its discretion under O.C.G.A. § 9-11-36(b)[95]—the employer's failure to respond

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[93] *Id.* at 784, 888 S.E.2d at 580.

[94] *Id.* at 784–85, 888 S.E.2d at 581.

[95] O.C.G.A. § 9-11-36(b) (1972).

conclusively established that he applied for and obtained coverage, and that he owed the outstanding balance. [96]

[96] *London*, 367 Ga. App. at 785–86, 888 S.E.2d at 582.

Workers' Compensation

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I. Legislation

The Survey period featured limited legislation.[1] House Bill 1409[2] increased the maximum rate of temporary total disability benefits from $675 to $725 and increased the maximum rate of temporary partial disability benefits from $450 to $483.[3] Similarly, the maximum amount of death benefits payable to a sole surviving spouse was increased correspondingly from $270,000 to $290,000.[4]

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[1] For analysis of workers' compensation during the prior survey period, *see* H. Michael Bagley & J. Benson Ward, *Workers' Compensation*, *Annual Survey of Georgia Law*, 73 MERCER L. REV. 303 (2021), https://digitalcommons.law.mercer.edu/cgi/viewcontent.cgi?article=2709&context=jour_mlr.

[2] Ga. H.R. Bill 1409, Reg. Sess. (2022), 2022 Ga. Laws 350 (codified at O.C.G.A. § 34-9-261 (2022)).

[3] *Id.* §§ 1–2.

[4] *Id.* § 3.

While not an amendment directly to the Workers' Compensation Act (the Act),[5] it is noteworthy that House Bill 389[6] amends the definition of "employment" applicable to the "Employment Security Law."[7] This definition now includes services performed for wages unless the Department of Labor makes a contrary determination based upon evidence that such individual has been, and will continue to be, free from control or direction over the performance of such services, including a list of characteristics to consider in making the determination of employment.[8]

II. Statute of Limitations for Catastrophic Request

The case of *Sunbelt Plastic Extrusions, Inc. v. Paguia*[9] dealt with the timing of an employer/insurer's last payment of income benefits and whether a claimant timely requested designation of her injury as "catastrophic" or whether her request was barred by the statute of limitations.[10]

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[5] O.C.G.A. §§ 34-9-1–432 (2022).

[6] Ga. H.R. Bill 389, Reg. Sess. (2022), 2022 Ga. Laws 499 (codified at O.C.G.A. § 34-8-35 (2022)).

[7] O.C.G.A. § 34-8-35 (2022).

[8] Ga. H.R. Bill 389, 2022 Ga. Laws 499 § 1.

[9] 360 Ga. App. 894, 862 S.E.2d 566 (2021).

[10] *Id.* at 894–95, 862 S.E.2d at 567.

The claimant incurred a compensable injury on March 31, 2009, and received 400 weeks of income benefits, with the 400 weeks ending on November 29, 2016.[11] On November 20, 2018, the claimant filed a form with the Georgia Board of Workers' Compensation requesting that her injury be deemed catastrophic. The employer/insurer countered that the claimant's request for catastrophic designation and additional income benefit payments was barred by the two-year statute of limitations contained in Official Code of Georgia Annotated section 34-9-104(b),[12] arguing that it had mailed the last payment of income benefits to the claimant more than two years before November 20, 2018. At a hearing, the Administrative Law Judge rejected the employer/insurer's statute of limitations defense and found the claimant's injury was catastrophic, and the Appellate Division of the State Board of Workers' Compensation (Appellate Division) affirmed, as did the Houston County Superior Court.[13]

The Georgia Court of Appeals addressed the employer/insurer's argument that the claimant's request was barred because the last income benefit payment was actually made more than two years before the claimant filed the request at issue.[14] O.C.G.A. § 34-9-104(b) provides a two-year statute of limitations for a claimant to seek

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[11] *Id.* at 894, 862 S.E.2d at 568.

[12] O.C.G.A. § 34-9-104(b) (2022).

[13] *Sunbelt*, 360 Ga. App. at 895, 862 S.E.2d at 568.

[14] *Id.*

additional workers' compensation benefits due to a change in condition, and the claimant's request for catastrophic designation is a request for a change in condition.[15] Claims for additional income benefits are time-barred if not brought within two years of that cessation date.[16] The court deferred to the Appellate Division's determination that a payment is "actually made" under O.C.G.A. § 34-9-104(b) when it is mailed to the recipient.[17] Therefore, the court's inquiry focused on whether the employer/insurer proved that it mailed the last payment of income benefits to the claimant more than two years before she filed her request for catastrophic designation on November 20, 2018.[18]

At the hearing before the Administrative Law Judge, the employer/insurer presented the testimony of the claims adjuster as to the general procedure and steps she followed in mailing income benefit checks to the claimant: she completed an instruction form for her administrative assistant to issue a check for the claimant's last two weeks of income benefits, and these forms prompted the administrative assistant to create a check that was printed in the office, and ordinarily, the checks were picked

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[15] *Id.* at 895–96, 862 S.E.2d at 568; O.C.G.A. § 34-9-104(b) (citing Williams v. Conagra Poultry of Athens, 295 Ga. App. 744, 746, 673 S.E.2d 105, 107 (2009)).

[16] *Sunbelt*, 360 Ga. App at 896, 862 S.E.2d at 568 (citing Roseburg Forest Prods. Co. v. Barnes, 299 Ga. 167, 169, 787 S.E.2d 232, 235 (2016)).

[17] *Sunbelt*, 360 Ga. App. at 896, 862 S.E.2d at 568.

[18] *Id.*

up for mailing each afternoon.[19] The claims adjuster testified that she was not the person who created or mailed the checks, and that she did not know exactly when the administrative assistant created the check to the claimant or when the administrative assistant placed the check in the location from which the person from the post office picked it up, though the claims adjuster testified to her belief that the check was mailed on November 15, 2016—the date printed on the check.[20]

Based on this evidence, the Appellate Division found testimony of the insurer's routine practice for issuing payments and found the claims adjuster completed the claims payment authorization form for the claimant on November 14, 2016, a check was printed, and it was picked up for mailing.[21] However, the Appellate Division further held that the employer/insurer did not present evidence about the time that elapsed between the various steps. It did not prove its contention of a one-day interval between the completion of the form and the mailing of the check, as there was no evidence that a one-day interval was part of the insurer's routine practice; no evidence as to the time that passed between the administrative assistant's receipt of the claims payment authorization form and the creation of the check in the computer system; and no evidence of the length of time between the creation of the check and the printing of the check. The Appellate Division determined that there was insufficient evidence to

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[19] *Id.* at 896–97, 862 S.E.2d at 568–69.

[20] *Id.*

[21] *Id.* at 897, 862 S.E.2d at 569.

determine when the check was mailed, other than some time after November 14, 2016, and thus the employer/insurer did not present sufficient evidence to meet its burden of proving its affirmative defense.[22]

Before the court of appeals, the employer/insurer argued that it was erroneously required to present evidence of a mailing receipt to prove the date of mailing, even though O.C.G.A. § 34-9-104(b) imposes no such requirement.[23] However, the court of appeals disagreed and noted that the Appellate Division acknowledged that evidence of an insurer's routine practice regarding the issuance and mailing of checks can be used to prove how and when a specific check was mailed, only in this case the employer/insurer failed to meet its burden of proof because it did not introduce evidence of the time between each step of its routine practice in creating and mailing checks.[24] Because some evidence supported the Appellate Division's findings, the court held that the employer/insurer failed to prove its statute of limitation defense by a preponderance of the evidence.[25]

The court then addressed the claimant's argument that it overruled the holding in *Lane v. Williams Plant Services*,[26] that a payment is "actually made" under O.C.G.A.

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[22] *Id.*

[23] *Id.* at 898, 862 S.E.2d at 569.

[24] *Id.* at 898, 862 S.E.2d at 569–70.

[25] *Id.* at 898, 862 S.E.2d at 570.

[26] 330 Ga. App. 416, 766 S.E.2d 482 (2014).

§ 34-9-104(b) when it is mailed to the recipient.[27] Rather, the claimant argued that the statute of limitations in O.C.G.A. § 34-9-104(b) should begin to run on the date benefits are suspended as shown in the WC-2 form filed with the State Board, as opposed to the date the check is mailed. The claimant contended that the current interpretation of the statute is unconstitutional because it deprives claimants of notice in violation of the Equal Protection and Due Process Clauses of the Georgia and United States Constitutions and that from a practical standpoint, this interpretation grants employer/insurers control over the statute of limitations based on when the employer mails the last payment of benefits.[28]

The court observed that the present case demonstrated that the rule in *Lane* can be problematic in practice, as there can be uncertainties in confirming when a payment was mailed, and the purpose of statutes of limitation are ill-served when the date a limitation period began to run becomes a litigated question of fact.[29] The court also suggested that the rule in *Lane* could be subject to manipulation where an employer/insurer combines the last two weekly payments to shorten the limitation period.[30] Nonetheless, the court declined to reconsider *Lane* under principles of

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[27] *Sunbelt*, 360 Ga. App. at 898, 862 S.E.2d at 570.

[28] *Id.* at 898–99, 862 S.E.2d at 570.

[29] *Id.*

[30] *Id.*

judicial restraint, as it was unnecessary to overrule that prior decision to decide the pending case, and left the matter as one to be considered by the General Assembly.[31]

III. Death and Dependency Benefits

In *Baxter v. Tracie McCormick, Inc.*,[32] an employee's surviving spouse sought to avoid the statutory cap on death benefits by arguing that her deceased mother-in-law was a partial dependent.[33] The deceased employee died in a work-related accident in 2012 and left behind a wife but no minor children and no other potential dependents. Accordingly, after his widow filed a claim for workers' compensation benefits, she began receiving full benefits pursuant to O.C.G.A. § 34-9-13(c).[34] After the employer/insurer paid the statutory maximum of $150,000 in death benefits to a sole surviving spouse under O.C.G.A. § 34-9-265(d),[35] it suspended her benefits in 2018. The widow requested a hearing with the State Board, arguing that O.C.G.A. § 34-9-265(d)'s cap on death benefits did not apply to her because she was not the sole dependent on the date of accident, as the deceased employee's mother was a partial dependent. The widow's mother-in-law had never brought a claim for death benefits before she passed away in 2017. The Administrative Law Judge found that the widow's

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[31] *Id.* at 899–900, 862 S.E.2d 570–71.

[32] 360 Ga. App. 445, 861 S.E.2d 406 (2021).

[33] *Id.* at 445, 861 S.E.2d at 406.

[34] *Id.* at 445, 861 S.E.2d at 407; *see* O.C.G.A. § 34-9-13(c) (2022).

[35] O.C.G.A. § 34-9-265(d) (2022).

mother-in-law was a partial dependent of the deceased employee, but never qualified as a dependent during her lifetime; the Appellate Division affirmed, as did the Fulton County Superior Court.[36]

The Georgia Court of Appeals observed that the widow, as the surviving spouse, was presumed under O.C.G.A. § 34-9-13(b)(1)[37] to be wholly dependent on the deceased employee, and under O.C.G.A. § 34-9-13(d)[38] when there is a whole dependent, then partial dependents cannot recover benefits.[39] Consequently, the mother-in-law was never eligible to receive benefits.[40] The mother-in-law had not qualified as a dependent while alive and had not made a claim for any benefits while alive.[41] The court of appeals also noted that the State Board of Workers' Compensation's determination that a posthumous claim of partial dependency would not disturb O.C.G.A. § 34-9-265(d)'s statutory cap on the amount of death benefits a sole surviving spouse may receive and was a reasonable interpretation of the Act.[42]

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[36] *Baxter*, 360 Ga. App. 445–46, 861 S.E.2d. at 406–07.

[37] O.C.G.A. § 34-9-13(b)(1) (2022).

[38] O.C.G.A. § 34-9-13(d) (2022).

[39] *Baxter*, 360 Ga. App. at 447, 861 S.E.2d at 408 (citing Stevedoring Servs. of Am. v. Collins, 247 Ga. App. 149, 542 S.E.2d 134 (2000)).

[40] *Baxter*, 360 Ga. App at 448–49, 861 S.E.2d at 409.

[41] *Id.* at 448, 861 S.E.2d at 408.

[42] *Id.* at 449, 861 S.E.2d at 409.

IV. Standard of Review

In *Padco Contracting, Inc. v. Hernandez*,[43] the claimant had a compensable claim after he fell from a scaffolding while working at his employer's construction site, injuring his right and left legs and his spine.[44] The claimant received workers' compensation income benefits and medical treatment, including for his lower left and right legs and his lumbar spine, and eventually his injury was designated "catastrophic."[45] When the claimant also sought treatment for his thoracic spine and his cervical spine, the employer/insurer denied this treatment. The claimant requested a hearing to pursue medical treatment for his thoracic and cervical spine, and the employer/insurer requested a change of authorized treating physician.[46]

The Administrative Law Judge found that the cervical and thoracic spine conditions were compensable and denied the employer/insurer's request for a change of physician.[47] The Appellate Division affirmed the finding that the thoracic spine condition was compensable, but ruled that the cervical spine condition was not. It found insufficient evidence of a causal relationship between the cervical injury and the work accident, but granted the employer/insurer's request for a change of physician.

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[43] 360 Ga. App. 765, 861 S.E.2d 459 (2021).

[44] *Id.* at 765, 861 S.E.2d at 460.

[45] *Id.* at 766, 861 S.E.2d at 460.

[46] *Id.*

[47] *Id.*

The claimant appealed to the Rockdale County Superior Court, which affirmed the change of physician request but reversed the Appellate Division's finding that the cervical spine injury was not compensable. The superior court concluded that the Appellate Division failed to consider medical evidence indicating a cervical condition prior to 2016.[48]

In its decision, the Georgia Court of Appeals first addressed the legal framework governing workers' compensation appeals, noting that the Appellate Division has broad authority to review an Administrative Law Judge's findings and may draw different factual conclusions based on its review of the record and analysis of the evidence; it may also substitute its own alternative findings.[49] However, neither the superior court nor the court of appeals may substitute itself as a factfinding body in lieu of the Appellate Division; instead, those reviewing courts must determine whether the Appellate Division's findings are supported by any evidence.[50]

With this standard of review in mind, the court held that the superior court erroneously conducted a *de novo* evidentiary review, instead of applying the "any-evidence" standard of review.[51] A subsequent appellate court may determine whether the Appellate Division improperly applied the law to undisputed facts or

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[48] *Id.*

[49] *Id.* at 766–67, 861 S.E.2d at 460–61.

[50] *Id.* at 767, 861 S.E.2d at 461.

[51] *Id.*

reached a decision based on an erroneous legal theory, however that was not the issue at hand in the present appeal.[52] Because at least some evidence supported the Appellate Division's finding that the claimant's cervical condition was not related to his 2008 accident, such a finding should be upheld on appeal, even though the record contained competing evidence.[53]

V. Standard of Review and Change of Condition

In *Express Employment Professionals v. Barker*,[54] the claimant fell at work and was treated for pain, including that in his left hip and back, and the claim was accepted as compensable with the employer/insurer paying the claimant income benefits.[55] After less than three months of medical treatment and receipt of income benefits, the claimant was placed at maximum medical improvement by a treating physician and released to full-duty work on October 26, 2018. The employer/insurer then suspended paying further income benefits. The claimant subsequently saw additional doctors, two of whom indicated that he continued to have low back pain as a result of his work injury. Prior to a hearing before the Administrative Law Judge, the claimant fell at

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[52] *Id.* at 768, 861 S.E.2d at 461.

[53] *Id.* at 768–69, 861 S.E.2d at 462.

[54] 361 Ga. App. 38, 862 S.E.2d 594 (2021).

[55] *Id.* at 38–39, 862 S.E.2d at 595–96.

home in April 2019 and landed in the same area impacted in his work injury. He then sought treatment from another doctor for low back pain.[56]

At a hearing on the claimant's request for recommencement of income benefits, the Administrative Law Judge found that the claimant underwent a change in condition for the better on October 26, 2018, and did not require further medical treatment nor have any disability as a result of his work accident and injury.[57] The judge further found that the claimant's fall at home in April 2019 was an unrelated intervening accident that was the cause of any current injury or disability which broke the chain of causation as contemplated by O.C.G.A. § 34-9-204(a).[58] The Appellate Division affirmed, however, the Carroll County Superior Court reversed the finding that the claimant had a subsequent intervening accident that broke the chain of causation and ruled that such a conclusion was inconsistent with the finding that the claimant had undergone a change of condition for the better on October 26, 2018.[59]

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[56] *Id.* at 39, 862 S.E.2d at 596.

[57] *Id.* at 40, 862 S.E.2d at 596.

[58] *Id.*; *see* O.C.G.A. § 34-9-204(a) (2022). Section 34-9-204(a) provides that "[n]o compensation shall be payable for the . . . disability of an employee . . . insofar as his or her disability, may be aggravated, caused, or continued by a subsequent nonwork related injury which breaks the chain of causation between the compensable injury and the employee's disability." *Id.*

[59] *Express Emp. Pros.*, 361 Ga. App. at 40, 862 S.E.2d at 596.

On appeal, the Georgia Court of Appeals ruled that the superior court improperly reversed the Appellate Division's finding because under the any-evidence standard of review, some evidence supported the Appellate Division's ruling.[60] Because some of the competing evidence included the medical opinion that the claimant had recovered from his work accident by October 26, 2018, it was error for the superior court to reverse the Appellate Division's finding that the claimant underwent a change of condition for the better.[61] Further, the court held that evidence existed to show that the claimant had a non-work-related fall at home in April 2019 where he again landed on his left hip and buttocks; this evidence supported the Appellate Division's finding that the claimant incurred a subsequent intervening accident which broke the chain of causation.[62] Last, the court observed that the findings of a change in condition for the better and a subsequent intervening accident which broke the chain of causation were not inconsistent, and again these conclusions were supported by evidence.[63] Accordingly, the any-evidence standard of review required affirming the Appellate Division's findings.[64]

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[60] *Id.*

[61] *Id.* at 41, 862 S.E.2d at 596–97.

[62] *Id.* at 41, 862 S.E.2d at 597.

[63] *Id.* at 42, 862 S.E.2d at 597.

[64] *Id.*

VI. Scheduled Lunch Break Exception

Although the Supreme Court of Georgia ruled in the previous survey period that an injury occurring on an employer's premises during an ordinary unpaid lunch break was compensable in *Frett v. State Farm Employee Workers' Compensation*,[65] during this Survey period, the Georgia Court of Appeals was compelled to reverse its earlier decision in *Daniel v. Bremen-Bowdon Investment Co.*[66] That decision was in turn based on the yet-to-be-reversed court of appeals' decision in *Frett v. State Farm Employee Workers' Compensation*.[67]

The claimant in *Daniel* left her work station for her regularly scheduled lunch break—during which time she was free to spend her time as she wished—and was walking down a public sidewalk to the company-owned parking lot when she tripped and fell, injuring herself.[68] The employer denied the claim, and the Administrative Law Judge relied upon *Rockwell v. Lockheed Martin Corp.*[69] to rule that the ingress and egress rule rendered the injury during the scheduled break compensable. The Appellate Division reversed, concluding that the injury did not arise out of her employment because it occurred while she was on a regularly scheduled break. The Carroll County

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[65] 309 Ga. 44, 844 S.E.2d 749 (2020) (hereinafter *Frett I*).

[66] 360 Ga. App. 716, 860 S.E.2d 229 (2021).

[67] 358 Ga. App. 138, 854 S.E.2d 347 (2021) (hereinafter *Frett II*).

[68] *Daniel*, 360 Ga. App. at 716, 860 S.E.2d at 230.

[69] 248 Ga. App. 73, 545 S.E.2d 121 (2001).

Superior Court affirmed, and the court of appeals originally affirmed.[70] However, after the decision in *Frett I*, the court of appeals reconsidered the application of the regularly scheduled lunch break in *Daniel*.[71]

The court of appeals followed *Frett I* to conclude that the claimant's accident both occurred in the course of employment, which was not in dispute, and arose out of the employment given that the regularly scheduled lunch break exception did not apply to the ingress and egress rule.[72] Thus, the superior court's decision affirming the Appellate Division's denial of benefits was reversed.[73]

VII. Subrogation

In *Bush v. Liberty Mutual Insurance Co.*,[74] the estate of an injured employee brought an action against the insurer for breach of fiduciary duty for an alleged failure to protect the estate's interest in the insurer's subrogation action against another driver under O.C.G.A. § 34-9-11.1.[75]

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[70] *Daniel*, 360 Ga. App. at 718, 860 S.E.2d at 231(citing *Frett II*, 358 Ga. App. at 138, 854 S.E.2d at 348).

[71] *Daniel,* 360 Ga. App. at 718, 860 S.E.2d at 231 (citing *Frett I*, 309 Ga. at 62, 844 S.E.2d at 763).

[72] *Daniel,* 360 Ga. App. at 718, 860 S.E.2d at 231.

[73] *Id.* at 719, 860 S.E.2d at 231.

[74] 361 Ga. App. 475, 864 S.E.2d 657 (2021).

[75] *Id.* at 476, 864 S.E.2d at 659; *see* O.C.G.A. § 34-9-11.1 (2022).

There, the employee was in a work-related motor vehicle accident in 2013, and the employer/insurer accepted the workers' compensation claim, commencing income benefits and medical treatment.[76] The employee also hired counsel to pursue a personal injury claim against the other driver, and the insurer notified employee's counsel of its subrogation lien pursuant to O.C.G.A. § 34-9-11.1. The employee settled his workers' compensation claim in 2015, and then passed away a few months later, ostensibly for reasons unrelated to the car accident. Shortly before the statute of limitations for the personal injury action expired, the insurer sued the other driver involved in the motor vehicle accident in its own name under O.C.G.A. § 34-9-11.1, as neither the employee nor his estate had brought an action against the other driver. Shortly before trial, the insurer settled the subrogation action for less than its subrogation lien, and the employee's estate did not timely intervene. The estate later filed suit, contending that the insurer breached its fiduciary duty to protect the estate's interest in the subrogation action, and the Troup County Superior Court granted the insurer's motion for summary judgment.[77]

On appeal, the Georgia Court of Appeals determined there was no fiduciary duty imposed on an insurer under O.C.G.A. § 34-9-11.1, noting other duties expressly created for an insurer including notice requirements, but no duty on an insurer to protect the employee's legal interests in its subrogation action brought under that

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[76] *Bush*, 361 Ga. App. at 477, 864 S.E.2d at 659.

[77] *Id.* at 477–78, 864 S.E.2d at 659–60.

statute.[78] The court observed that the insurer's subrogation action is a derivative one, and the employee has the exclusive right to bring an action for a year; subsequently, an employee may intervene in an action brought by the insurer.[79] The court noted that a reading of the statute which leaves the onus to protect the employee's interests on the employee, rather than shifting that responsibility to an insurer or employer, makes practical sense in the context of the statutory scheme.[80] The court also observed that often the interests of the insurer and employee in subrogation actions are not aligned, as the insurer may have little incentive to pursue recovery above the amount of its subrogation lien whereas generally the employee would want to maximize recovery. These competing incentives can result in different litigation decisions.[81] Further, the insurer had a contractual relationship with the employer, not with the employee.[82] Therefore, the court of appeals agreed with the trial court that O.C.G.A. § 34-9-11.1 does not impose a fiduciary duty on the insurer to act in the best interests of the employee.[83]

VIII. Insolvency Pool

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[78] *Id.* at 478–79, 864 S.E.2d at 660.

[79] *Id.* at 479, 864 S.E.2d at 661.

[80] *Id.* at 480, 864 S.E.2d at 661.

[81] *Id.*

[82] *Id.* at 481, 864 S.E.2d at 662.

[83] *Id.*

In the case of *Palmer v. Georgia Insurers Insolvency Pool*,[84] the Georgia Court of Appeals held that the Georgia Insurers Insolvency Pool did not have authority to bring a parallel action in the DeKalb County Superior Court that directly implicated a pending workers' compensation claim.[85]

The claimant in *Palmer* incurred a work-related accident in July 2017 as the result of a motor vehicle accident.[86] Her workers' compensation claim was accepted as compensable, and she received medical treatment and income benefits. Later that year, the workers' compensation insurer for the claimant's employer became insolvent, and pursuant to the Georgia Insurers Insolvency Pool Act,[87] the Georgia Insurers Insolvency Pool became responsible for her claim. The Insolvency Pool had paid just under $25,000 on her claim. The claimant also submitted claims to the at-fault driver's automobile liability insurer and to her own automobile liability insurer. The claimant settled her personal injury claims with the carriers for $25,000 and $50,000, respectively. After her counsel informed the Insolvency Pool of the funds recovered, the Insolvency Pool filed suit against the claimant seeking (1) a set-off of the $75,000 that the claimant received from other insurers, (2) a ruling that it is not obligated to issue any payments on the workers' compensation claim until the set-off amount is reached,

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[84] 361 Ga. App. 803, 865 S.E.2d 623 (2021).

[85] *Id.* at 803, 865 S.E.2d at 624.

[86] *Id.*

[87] Georgia Insurers Insolvency Pool Act, O.C.G.A. §§ 33-36-1 through 10 (2022).

and (3) a refund from the claimants for all amounts the Insolvency Pool paid on her workers' compensation claim. The Insolvency Pool argued that O.C.G.A. §§ 33-36-14(a)[88] and (b)[89] as well as the decision in *Georgia Insurers Insolvency Pool v. DuBose*[90] authorized its requested relief. The superior court granted the Insolvency Pool's motion for summary judgment, and the claimant appealed.[91]

The court of appeals first discussed the Insolvency Pool Act, noting that the Insolvency Pool is "intended to be a safety net for those whose insurers go out of business" and provides benefits "only when there is no other insurance available"; therefore a claimant may not necessarily receive the same recovery from the Insolvency Pool as she may have received from a solvent insurer.[92] The Insolvency Pool is authorized to bring an action to recover amounts paid to a claimant "in excess of the amount authorized" by the Insolvency Pool Act.[93] O.C.G.A. § 33-36-14(a)'s set-off provision reads as follows:

> Except as provided for in Code Section 33-36-20, any person having a claim against a policy or an insured under a policy issued by an insolvent insurer, which claim is a covered claim and is also a claim within the coverage of any

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[88] O.C.G.A. § 33-36-14(a) (2022).

[89] O.C.G.A. § 33-36-14(b) (2022).

[90] 349 Ga. App. 238, 825 S.E.2d 606 (2019).

[91] *Palmer*, 361 Ga. App. at 803–04, 865 S.E.2d at 624.

[92] *Id.* at 804, 865 S.E.2d at 625 (quoting *Dubose*, 349 Ga. App. at 246, 825 S.E.2d at 613).

[93] *Palmer*, 361 Ga. App. 804, 865 S.E.2d at 625.

> policy issued by a solvent insurer, shall be required to exhaust first his or her rights under such policy issued by the solvent insurer. The policy of the solvent insurer shall be treated as primary coverage and the policy of the insolvent insurer shall be treated as secondary coverage and his or her rights to recover such claim under this chapter shall be reduced by any amounts received from the solvent insurers.[94]

While the set-off provision was discussed in *DuBose*, the court of appeals's holding in that case was limited to establishing what amounts received by a claimant from another insurer may be considered in determining the set-off amount under O.C.G.A. § 33-36-14(a).[95] The court of appeals observed in the present case that *DuBose* did not authorize the Insolvency Pool to bring a parallel action in the superior court to obtain a refund of benefits paid in connection with a pending workers' compensation claim or to alter the payment obligations imposed on the Insolvency Pool under the Workers' Compensation Act.[96]

Further, O.C.G.A. § 33-36-14(a) does not create an independent cause of action allowing the Insolvency Pool to file suit to enforce the set-off provision, and O.C.G.A. § 33-36-14(b) may create an independent cause of action but this is limited to the amount paid a claimant "in excess of the amount authorized" by the Insolvency Pool Act.[97] Because the claimant's workers' compensation claim remained pending before

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[94] O.C.G.A. § 33-36-14(a).

[95] *Palmer*, 361 Ga. App. at 805, 865 S.E.2d at 625 (citing *Dubose*, 349 Ga. App. at 241, 825 S.E.2d at 610).

[96] *Palmer*, 361 Ga. App. at 805, 865 S.E.2d at 625–26.

[97] *Id.* at 806, 865 S.E.2d at 626.

the State Board of Workers' Compensation with no specific decision from the Board as to the amount of benefits to which the claimant was entitled, the court concluded that the Insolvency Pool could not yet establish that its payments to the claimant exceeded the amount authorized by the Insolvency Pool Act.[98]

Rather than bring a parallel action in superior court, the Insolvency Pool's remedy would be before the State Board of Workers' Compensation.[99] The court of appeals ruled that the resolution of the Insolvency Pool's claims fell within the subject matter jurisdiction of the State Board, as the claims are ancillary or directly related to the resolution of the claimant's pending claim for workers' compensation benefits.[100] The court vacated the superior court's grant of summary judgment to the Insolvency Pool and remanded to the superior court with direction to dismiss the Insolvency Pool's complaint, noting that the Insolvency Pool must litigate the issues before the State Board.[101]

IX. Interlocutory Appeals

In *Newton County Board of Education v. Nolley*,[102] the Georgia Court of Appeals disallowed a request for an interlocutory appeal past the Appellate Division when the

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[98] *Id.*

[99] *Id.*

[100] *Id.* at 806–08, 865 S.E.2d at 626.

[101] *Id.* at 808–09, 865 S.E.2d at 627–28.

[102] 363 Ga. App. 625, 871 S.E.2d 884 (2022).

underlying workers' compensation claim remained pending before the State Board's trial division.[103]

The claimant in *Nolley* sustained a compensable injury in 2008, for which he received temporary total disability (TTD) income benefits until May 2016, and then received permanent partial disability (PPD) benefits until September 2016.[104] In November 2016, the claimant requested a hearing to have his claim designated catastrophic and seeking further TTD benefits. He filed another request for catastrophic designation of the claim approximately six months later, then his hearing request was removed from the docket. In October 2018, the claimant filed a new hearing request, but again removed that hearing request from the active docket. Finally, the claimant renewed his hearing requests in July and December 2020, and the employer/insurer contested these new filings for TTD benefits on grounds that O.C.G.A. § 34-9-104(b)'s two-year statute of limitations barred any further claim for income benefits.[105] The Administrative Law Judge found that the claimant's November 2016 hearing request "continue[d] to be viable, and [wa]s not barred by the change-in-condition statute of limitations," and both the Appellate Division and Newton County Superior Court affirmed.[106]

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[103] *Id.* at 625, 871 S.E.2d at 885.

[104] *Id.* at 626, 871 S.E.2d at 885.

[105] *Id.*

[106] *Id.*

The employer/insurer sought discretionary review of the order; however, the court of appeals ruled that the superior court did not have jurisdiction to review the decision of the Appellate Division.[107] Section 34-9-105(b)[108] provides for appeals from final awards and judgments, but the court noted that the Workers' Compensation Act does not provide for interlocutory appeals.[109]

The court of appeals observed that the case remained pending before the trial division of the State Board of Workers' Compensation because the Administrative Law Judge found that the claimant's hearing request "continue[d] to be viable" and the Appellate Division adopted and affirmed this award.[110] With the case confirmed to be pending before the trial division, the court of appeals held that the superior court should have declined review, as it was an unauthorized interlocutory appeal.[111] The court reversed the superior court's decision, instead directing it to dismiss the appeal as premature.[112]

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[107] *Id.*

[108] O.C.G.A. § 34-9-105(b) (2022).

[109] *Newton*, 363 Ga. App. at 626, 871 S.E.2d at 885.

[110] *Id.* at 626–27, 871 S.E.2d at 885–86.

[111] *Id.* at 627, 871 S.E.2d at 886.

[112] *Id.*

SUMMARY OF 2023 AMENDMENTS TO THE RULES OF THE STATE BOARD OF WORKERS' COMPENSATION

The 2023 Rules, effective July 1, 2023, contain organizational, editorial, and substantive changes. This summary of the 2023 amendments to the Rules is intended as a convenient reference and should not be considered an exhaustive description of all rules changes. For detailed information regarding changes to a particular rule, please refer to the published version of the rule.

Rules 100 and 102 (E)(1)
Requires professional conduct during the course of a workers' compensation claim.

Rules 61(b)(24) and 108(d)
Requires an attorney who has been terminated to follow the same procedures as an attorney who wishes to withdraw from representation.

Rule 105
Changes made to correspond to statutory changes to O.C.G.A. § 34-9-105 that became effective July 1, 2023, affecting the process for filing appeals of Appellate Division awards with the Superior Court.

Rule 200.2
Increases communication transparency between the medical case manager and all parties to the claim.

Rule 203(e)
Increases mileage reimbursement rate from 40 cents to 45 cents.

Rule 203(c)(9)
In a medical fee dispute resolved by an authorized peer review organization, the loser is required to pay the fee of the peer review organization.

MINUTES

RULES AND REGULATIONS
OF THE
STATE BOARD OF WORKERS' COMPENSATION

The Board, pursuant to a motion duly made and seconded, has adopted the following Rules and Regulations. The enforcement date for the changes to the Rules is July 1, 2023.

This, the 1st day of July, 2023.

Benjamin J. Vinson /s/
CHAIRMAN

Frank R. McKay /s/
DIRECTOR

Neera Bahl /s/
DIRECTOR

ATTEST:

Delece A. Brooks /s/
EXECUTIVE DIRECTOR

RULES AND REGULATIONS OF THE STATE BOARD OF WORKERS' COMPENSATION APPENDIX

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Rule 2. Procedure to Elect Coverage, Reject Coverage or Revoke Exemption.

(a) Corporate officers and limited liability company members electing to be exempt from coverage or electing to revoke exemption and reinstate coverage shall file Form WC-10 with the insurer, if there is an insurer, and, if none, then with the Board.

(b) Farm labor employers electing coverage or electing to revoke previously elected coverage shall file Form WC-10 with the insurer, if there is an insurer, and, if none, then with the Board. If an employer elects to revoke previously elected coverage, the employer must give written notice to each affected employee and must maintain adequate documentation of such notice.

(c) A partner or sole proprietor electing coverage or electing to revoke previously elected coverage shall file Form WC-10 with the insurer, if there is an insurer, and, if none, then with the Board.

Rule 12. Publication of Board Decisions.

The Board or its designee may publish awards and orders of the Appellate Division and the administrative law judges provided adequate security measures are taken to protect the identity and privacy of the parties. In order to protect the identity and privacy of the parties, Board decisions will be published without the names and addresses of the parties. The Board may redact such other information from published awards and orders as it deems appropriate.

Rule 13. Termination of Dependency.

(a) The employer/insurer may terminate dependency benefits on the basis of a meretricious relationship only by order of the Board.

(b) In all other cases of termination of dependency, Rule 61(b)(3) shall apply.

Rule 15. Stipulated Settlements.

(a) The party submitting the stipulation shall:

(1) file the original with a copy for each party to the agreement; if filing

electronically, file one original and no copies.

(2) at the top page of each stipulation list the names, addresses, and telephone numbers of all parties to the agreement, the ICMS Board claim number(s) of the employee, the dates of accident covered by the agreement where a Board file has been created by a Form WC-1 or Form WC-14, the names and addresses of all attorneys with a designation of which parties they represent, and the Federal tax identification number of the employee's attorney. For dates of accident where a Board file has not been created but covered by the stipulation, such dates of accident shall only be listed in the body of the agreement.

(3) File a WC-1 with the Board with Section B, C, or D completed for each date of accident included in the caption in order for the settlement agreement to be approved by the Board, unless such WC-1 has previously been filed.

(4) If an attorney fee contract has not previously been filed with the Board, attach a copy of the fee contract of counsel for the employee/claimant;

(5) When submitting a stipulation for approval by electronic mail, the stipulation must be submitted separately from supporting documentation.

(6) Approval of a stipulation may be sent by electronic mail to the parties and attorneys of record. Whenever electronic transmission is not available, approval will be sent by mail.

(7) For all stipulations, at the top of the first page of the stipulation, the first five inches shall be left blank for the approval stamp;

(8) All stipulations shall be limited to no more than 25 pages, unless prior approval is given by the Board or the Settlement Division.

(b) A stipulation which provides for liability of the employer or insurer shall:

(1) state the legal and/or factual matters about which the parties disagree; and,

(2) state that all incurred medical expenses which were reasonable and necessary have been or will be paid by the employer/insurer. If the parties have agreed for medical treatment to be provided for a specific period in the future, then the stipulation must so state, and must further specify whether the agreement is limited to certain specific providers, and whether those providers may refer to others if needed. Furthermore, the stipulation shall provide that the parties will petition the Board for a change of physician in the event that a specifically named physician is unable to render services, and the parties cannot agree. If the stipulation does not contain a provision that medical expenses may be incurred for a specific period in the future after the approval of the stipulation, then the stipulation must contain a statement which explains why that provision is not necessary.

(3) Attach the most recent medical report or summary which describes the medical condition of the employee, including a very brief statement of the surgical history, if any, if that history is not already specified within the stipulation. The entire medical record should NOT be attached.

(c) The insurer shall certify that it has complied with O.C.G.A. § 34-9-15 by having sent a copy of the proposed settlement to the employer prior to any

*p*arty having signed it.

(d) When the agreement provides for the employer/insurer to fund any portion of the settlement by purchase of an annuity or other structured settlement instrument, which provides for a third party to pay such portion of the settlement, then the stipulation must contain a provision that the employer and insurer will be liable for the payments in the event of the default or failure of the third party to pay. In addition, if the stipulated settlement agreement provides for a Medicare Set-Aside (MSA), the stipulated settlement agreement shall contain a provision as to the actual or projected cost of the MSA.

(e) Unless otherwise specified in the attorney fee contract filed with the Board and in the terms of the stipulation, the proceeds of the approved stipulated settlement agreement shall be sent directly to the employee or claimant. If an attorney is to be paid, the stipulation must state the amount of the fee, and itemize all expenses which should be reimbursed. Any expense, cost, surcharge, flat fee or averaged expenditure which is not reasonable and solely related to the case being settled shall not be approved by the Board. Further, an attorney shall not receive an attorney's fee as a portion or percentage of any medical treatment or expenses, or any money designated for medical treatment or expenses. Expenses and attorney fees shall be paid in a check payable to the attorney only, and proceeds due to the employee shall be paid in a check payable to the employee only and the attorney shall certify that the expenses comply with Rule 1.8(e) of the Georgia Rules of Professional Responsibility and Board Rule 108. No portion of any settlement payment shall be designated as medical except the amount specified in the approved stipulation.

(f) In all no-liability settlements where the claimant is represented by counsel, the attorney must submit a Form WC-15 certifying that any fee charged is fair and reasonable and does not exceed twenty five percent as allowed under the provisions of O.C.G.A. § 34-9-108 and Board Rule 108.

(g) Stipulations which contain waivers or releases of causes of action over which the Board has no jurisdiction will not be approved by the Board.

(h) The Board may hear evidence or make confidential informal inquiry regarding any settlement.

(i) When filing a motion for reconsideration on the approval or denial of a settlement, the parties or attorneys shall: (1) immediately notify the Division Director of the Settlement Division or the Board by telephone call; (2) use the ICMS doc-type labeled motion for reconsideration; (3) limit their request to 10 pages, including briefs and exhibits, unless otherwise permitted by the Board; and (4) serve a copy on all counsel and unrepresented parties, along with supporting documents, including a separate certificate of service identifying the names and addresses served.

(j) In any stipulated settlement agreement where review by the Centers for Medicare and Medicaid Services (CMS) is available, the parties elect to pursue approval of the proposed Medicare Set Aside (MSA) by CMS, and the parties elect to submit the settlement agreement to the Board for approval prior to CMS approval, the parties shall acknowledge and agree that the State Board of Workers' Compensation shall retain jurisdiction of those medical issues covered by the MSA

until such time as the medical portion of the claim is resolved in accordance with the Workers' Compensation Act.

(k) No party or any party's attorney shall enter into a loan or assignment with a third party creditor which requires repayment from the proceeds of a workers' compensation claim.

(l) The employee shall stipulate that there are no outstanding child support liens that would prohibit full disbursement of the settlement funds in this case.

(m) For settlements of $5000.00 or more, the Board or any party to the settlement agreement may require that the settlement documents contain language which prorates the lump sum settlement over the life expectancy of the injured worker.

(n) Settlements in compensable claims will not be approved unless all WC-206/WC-244 party at interest issues are resolved.

(o) In all no-liability settlements, the parties shall submit a statement specifying the party responsible for outstanding medical expenses.

Rule 24. Procedure for Enforcement Division to Request a Hearing.

(a) The Fraud and Compliance Unit created pursuant to O.C.G.A. §34-9-24 shall be known as the Enforcement Division of the State Board of Workers' Compensation.

(b) A request for an action or proceeding may be filed by the State Board of Workers' Compensation Enforcement Division to determine the assessment of civil penalties against any person or entity who has violated the provisions of Chapter 9 of Title 34. The request shall be filed on Form WC-24 and then assigned to an Administrative Law Judge for review. Hearings shall be conducted pursuant to O.C.G.A. § 34-9-102 and Board Rule 102. In addition, venue may be determined as provided by law pertaining to that person or entity.

(c) Any party appealing a decision of the Administrative Law Judge shall do so pursuant to O.C.G.A. §§ 34-9-103 and 34-9-105, and Board Rules 103 and 105.

(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.

Rule 40. Offices and Addresses of the Board; Sessions.

The offices of the State Board of Workers' Compensation are located as follows:

Atlanta:
270 Peachtree Street, N.W.
Suite 400
Atlanta, GA 30303-1299
Phone: (404) 656-3875
1-800-533-0682

www.sbwc.georgia.gov

Albany:	414 Westover Blvd. Suite C Albany, GA 31707 (physical address) P.O. Box 71985 Albany, GA 31708 (mailing address) Phone: (229) 430-4280
Columbus:	Heritage Tower, Suite 200 18 9th Street Columbus, GA 31901 Phone: (706) 649-1103
Dalton:	475 Reed Road N.W. Suite 102 Dalton, GA 30720 Phone: (706) 272-2284
Gainesville:	Suite D 601 Broad Street, N.E. Gainesville, GA 30501 Phone: (770) 531-5625
Macon:	Suite A. 110 Holiday Drive N. Macon, GA 31210-1802 Phone: (478) 471-2051
Savannah:	35 Barnard Street Suite 301 Savannah, GA 31401 Phone: (912) 651-6222

The Board shall meet in Atlanta, or elsewhere as necessary, at the call of the Board.

Rule 48. Reserved.

Rule 59. Adoption and Amendment of Rules of the Board

(a) The Board may adopt or amend rules whenever deemed necessary. However, except in extraordinary circumstances, rule changes shall only be considered and adopted annually, to be effective on July 1 of each year.

(b) No less than 45 days prior to the adoption, amendment, or repeal of any rule, the Board shall:

1) Publish on the Board's website a notice consisting of an exact copy of the proposed new rule or in the case of an amendment to an existing rule, a copy which highlights all changes. The notice shall include a statement that interested persons will have 30 days within which to submit data, views, or arguments in writing regarding any specific proposed new rule or amendment.

2) The Board shall consider fully all written submissions respecting the proposed new rule or amendment.

3) At the discretion of the Board, input may also be received in other formats, including but not limited to public hearings.

4) Provide a copy of the proposed new rule or amendment to the Chairman of the Board's Advisory Council and all members of the Board's Advisory Council.

5) Provide a copy of the proposed new rule or amendment to the Chairman of the Senate Insurance and Labor Committee and the Chairman of the House Industry and Labor Committee. If requested by the Chairman of the Senate Insurance and Labor Committee or the Chairman of the House Industry and Labor Committee before the effective date of the adoption, amendment, or repeal of any rule, the Board shall hold a public hearing on the proposed changes.

6) The notice process detailed in this rule shall be repeated one time for any specific proposed new rule or amendment that is changed by the Board following a public hearing. Notice of the public hearing shall be published on the Board's website no less than 7 days in advance of the public hearing.

Rule 60. Assignment of Identification Numbers for Claimants; Form of Documents Submitted to Board; Enforcement Powers.

(a) Upon receipt of notice of a work-related injury, the Board shall assign a claim number. All subsequently filed forms, reports, or any other correspondence or documents related to or concerning such work-related injury shall have affixed thereto the assigned claim number, date of injury, and claimant's name. Failure to include this information with the filing may result in the rejection of the filing with the Board.

(b) Written instructions on all workers' compensation forms are deemed to be included in these rules.

(c) The Board shall have the power to issue writs of fieri facias in order to collect fines imposed by any member of the Board or any Administrative Law Judge against any person. Such writs may be enforced in the same manner as a similar writ issued by a superior court.

(d) Pleadings, forms, documents, or other filings shall be filed with the Board electronically through ICMS or EDI, unless otherwise authorized in these Rules. However, in the event of an outage preventing an electronic submission and the time for filing is at issue, the document may be filed in paper or by facsimile with any Board office. Any filing by facsimile transmission must be clearly labeled with the name of the claimant, claim number, and Board division or employee to

whom the facsimile transmission is directed. The certificate of service, showing concurrent service upon the opposing party electronically or by facsimile transmission shall be a part of any electronic or facsimile transmission. Failure to include a certificate of service shall invalidate the filing. All facsimile transmissions must be identical to the originals and must be legible. The Board, within its discretion, may transmit documents by facsimile or electronic transmission.

(e) (1) Pursuant to Code Section 10-12-2 *et seq*, when a signature is required for any electronic filing with the Board, the party or attorney shall type his or her name in the appropriate fields on the document or Board form submitted for filing. Submission of a filing in this manner shall constitute evidence of legal signature by those individuals whose names appear on the filing.

(2) Any party or attorney challenging the authenticity of an electronically filed document or electronic signature on that filing must file an objection to the document within 15 days of receiving the notice of the electronic filing. The burden shall be on the party challenging the authenticity of the signature.

(f) In order to create a workers' compensation ICMS file at the Board, a Form WC-1 or Form WC-14 shall be filed with the Board. Any document or form filed with the Board, when either a Form WC-1 or Form WC-14 has not been previously filed, shall be rejected by the Board.

(g) Only the original of any form, document, or other correspondence shall be filed with the Board. Duplicate originals shall not be filed with the Board. Where providing a courtesy copy to an Administrative Law Judge or the Board, that document shall be identified clearly and prominently as a courtesy copy.

(h) Service upon a party or attorney of any form, document, or other correspondence shall be by electronic mail. Whenever electronic mail is not available, service shall be by U.S. Mail.

(i) Any user of ICMS who agrees to comply with the ICMS "Terms and Conditions" and willfully violates those terms and conditions shall be in violation of these rules and subject to the assessment of civil penalties pursuant to O.C.G.A §34-9-18.

Rule 61. Publication of Notice of Operation Under the Act; Forms.

(a) All employers operating under the Georgia Workers' Compensation Law shall post notice as hereinafter provided upon durable material publicly and permanently in a conspicuous place in each business location. The Board's website address is www.sbwc.georgia.gov. Upon request, the Board will furnish suitable notices free of charge. The notice shall be in such form that it can be understood by all employees and read as follows:

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

If the worker is hurt or injured at work, the employer/insurer shall pay medical and rehabilitation expenses within the limits of the law. In some cases, the employer will also be required to pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days.

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of Board forms on file with the employer pertaining to an employee's claim.

The Board may excuse lack of notice of injury if the employer does not follow the foregoing requirements for posting notice. [O.C.G.A. § 34-9-80]

(b) The Board furnishes, upon request, copies of forms required by law. Use originals of the forms or approved copies of the original forms. The text and format of a Board form may not be altered, except with the specific written permission of the Executive Director. Generally, when filing any Board form or document with the Board, file only the original and no copies. Do not use tabs to separate documents.

ANYONE USING A BOARD FORM MUST USE THE MOST CURRENTLY REVISED VERSION OF THE FORM. INSTRUCTIONS ON THE BACK OF ANY BOARD FORM SHALL BE SENT TO THE EMPLOYEE AND SHALL NOT BE FILED WITH THE BOARD.

Pleadings, forms, documents, or other filings shall be filed with the Board electronically through ICMS or EDI, unless otherwise authorized in these Rules. Whenever an attachment to a filing or submission is required, the employer/insurer shall simultaneously electronically file or mail to the Board a copy of the form and the attachment. 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 may be rejected by the Board.

ANY FORM FILED WITH THE BOARD IN ICMS, THROUGH EDI OR IN PAPER MUST ALSO BE PROPERLY SERVED ON THE OPPOSING PARTY BY ELECTRONIC MAIL BY THE FILING PARTY. WHENEVER ELECTRONIC MAIL IS NOT AVAILABLE, SERVICE SHALL BE BY UNITED STATES MAIL. NOTICES OF FILINGS GENERATED BY ICMS DO NOT CONSITITUTE PROPER SERVICE OF FORMS FILED WITH THE BOARD.

THE EMPLOYER, INSURER, SELF-INSURER, GROUP SELF-INSURER OR THEIR LEGAL REPRESENTATIVE SHALL COMPLETELY FILL OUT THE FORM WC-1 AND FAILURE TO PROVIDE THE VALID NAME AND ADDRESS OF THE EMPLOYEE, EMPLOYER, INSURER, SELF-INSURER, OR GROUP SELF-INSURER (INCLUDING THE INSURER 5-DIGIT SBWC ID NUMBER), DATE OF

INJURY, THE EMPLOYEE'S DATE OF BIRTH, AND THE COMPLETION OF SECTIONS B, C, OR D MAY RESULT IN THE REJECTION OF THE FILING WITH THE BOARD.

(1) **Form WC-1. Employer's First Report of Injury.** Employers shall complete Section A immediately upon knowledge of an injury and submit the form to their insurer.

Insurers, self-insurers or group self-insurers who receive a Form WC-1 from an employer shall clearly stamp or otherwise indicate the date of receipt on the form. Insurers, self-insurers or group self-insurers shall complete Section B, C, or D and file the original with the Board and furnish a copy to the employee within 21 days of the employer's knowledge of disability, injury or death. In accepted catastrophic claims, Form WC-1 shall be filed within 48 hours of the employer's acceptance of a catastrophic injury as compensable.

Complete Section B when the insurer/self-insurer/group self-insurer commence payment of weekly benefits or when the employer continues to pay salary during compensable disability and when employer/insurer suspend for an actual return to work prior to the filing of Form WC-1.

Complete Section C in accordance with subsection (d) of O.C.G.A. § 34-9-221 when employer/insurer controverts payment of compensation. Furnish copy to employee and, upon request, to any other person with a financial interest in the claim.

Complete Section D when no indemnity benefits are due and/or the claim has not been controverted.

(2) **Form WC-2. Notice of Payment or Suspension of Benefits.** File Form WC-2 to commence, suspend, or amend the weekly benefit payment under O.C.G.A. §34-9-261, O.C.G.A. §34-9-262, or O.C.G.A. §34-9-263, including payment of salary for compensability, or when a change in disability status occurs after Form WC-1 has been properly filed with the Board. File when suspending O.C.G.A. § 34-9-261 benefits and commencing O.C.G.A. § 34-9-262 benefits pursuant to § 34-9-104(a)(2). Serve a copy of the Form WC-2 and attachments, if any, on the employee and the employee's attorney, if one has been retained. *See* Rule 221. If the last payment is intended to close the case, file final Form WC-4 with the Board.

(3) **Form WC-2A. Notice of Payment or Suspension of Death Benefits.** Use in death case in lieu of Form WC-2. Use when change in dependency occurs. Use this form when making a payment to the State of Georgia for no dependents.

(4) **Form WC-3. Notice to Controvert.** Complete Form WC-3 to controvert when a Form WC-1 has previously been filed. Furnish copies to employee and any other person with a financial interest in the claim

including, but not limited to, the treating physician(s) and attorney(s) in the claim. *See* subsections (d), (h), and (i) of O.C.G.A. § 34-9-221 and Rule 221.

(5) **Form WC-4.** Case Progress Report. File as follows:

(A) In all claims, within one year of the first date of disability, injury or death;

(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 Form WC-4 on all open cases;

(E) To reopen a case;

(F) Within 30 days of final payment made pursuant to an approved stipulated settlement;

(G) Within 90 days of receipt of an open case by the new third party administrator.

(6) **Form WC-6. Wage Statement.** File when the weekly benefit is less than the maximum under O.C.G.A. § 34-9-261 or § 34-9-262 and furnish a copy to the employee. If a party makes a written request of the employer/insurer, then the employer shall send the requesting party a copy of the Form WC-6 within 30 days.

(7) **Form WC-10. Notice to Elect or Reject Coverage.** A sole proprietor or partner must file this form to elect coverage under the provisions of O.C.G.A. §34-9-2.2. The employer must file this form in order that the corporate officer or limited liability company member be exempt from coverage, or to revoke their previously filed exemption. Rejection becomes effective the date of filing with the insurer. Where the employer has workers' compensation insurance coverage, the employer must send this form to their workers' compensation insurer. If no workers' compensation coverage is in place, file this form with the Board.

The farm labor employer must file this form in order to request coverage for farm laborers, or to revoke their previously filed request.

(8) **Form WC-11. Standard Coverage Form.**

(9) **Form WC-12. Request for Copy of Board Records.** Any party requesting a copy of Board records shall file their request on this form. The Board's file will include any document or form submitted by the parties to a claim or any document transmitted by the Board. Any party who receives a copy of a Board record pursuant to their request shall pay the charges due within 30 days of receipt of an invoice from the Board.

(10) **Form WC-14. Notice of Claim/Request for Hearing or Mediation.** File to provide notice of a claim, request a hearing, or request a mediation conference. The employee or employee's attorney shall completely fill out the Form WC-14 and must provide the valid name and address of the employee, employer, insurer, self-insurer or group insurer (including the insurer 5-digit SBWC ID number), date of injury, employee's date of birth, and other information as stated on the Form WC-14. Specific body parts injured must be listed on the WC-14. Furnish a copy of Form WC-14 to all other parties, per Rule 60(j) and Rule 61(b). WC-14s filed on paper that are rejected by the Board due to insufficient information for processing shall

retain the original filing date if the WC-14 (showing the original filing date) is properly completed and returned to the Board.

(11) **Form WC-14A. Request to Change Information on a Previously Filed Form WC-14.**

The following information can be changed on this form: the date of injury (plus or minus 30 days from the date of injury on the WC-14), correction of an employer's name, dismissal of an employer, insurer, self-insured employer, or claims office. Hearing/mediation issues may also be added on this form (This form can only be filed by the party who filed the WC-14.) **A form WC-14A shall not be used to change an address of record, add additional parties, or additional dates of injury.** A new Form WC-14 shall be filed with the Board to add an additional date of injury, to add or amend any information pertaining to the employer, insurer, self-insured employer, claims office, or part of body injured.

(12) **Form WC-15. Attorney Certification for No-Liability Stipulated Settlements.**

Must be attached to all no-liability stipulated settlements.

(13) **Form WC-20(a). Medical Report.** This report and/or the 1500 Claim Form, and/or UB-04 shall be completed and filed as follows:

(A) The attending physician or other practitioner makes the report and forwards it along with office notes and other narratives to the employer/insurer as follows:

(i) Within seven days of initial treatment;

(ii) Upon the employee's discharge by the attending physician;

(iii) At least every three months until the employee is discharged;

(iv) Upon the employee's release to return to work;

(v) When a permanent partial disability rating is determined.

(vi) Pursuant to Rule 203(b).

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

(i) When the report contains a permanent partial disability rating;

(ii) Upon request of the Board; and,

(iii) To comply with other rules and regulations of the Board.

(C) 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 this rule and Rule 200(c).

(14) **Form WC-24. Enforcement Division Request for Board Intervention.**

For use by Enforcement Division only.

(15) **Form WC-25. Application for Lump Sum/Advance Payment.** See Board Rule 222.

(16) **Form WC-26. Consolidated Yearly Report of Medical Only Claims and Annual Payments on Indemnity Claims.**

File on or before March 1st 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.

(17) **Form WC-100. Request for Settlement Mediation.**

To be used when a party is requesting a settlement mediation.

(18) **Form WC-102. Request for Documents from Parties.**

Prior or subsequent to a hearing being requested in a claim, the parties shall be entitled to request copies of documents listed in this form from the opposing parties, and the named documents shall be provided to the requesting party within 30 days of the date of certificate of service, subject to penalties for failure to comply.

(19) **Form WC-102B. Notice of Representation by an attorney for an employer, insurer, or party-at-interest.**

A claimant's attorney shall file a notice of representation by filing their attorney fee contract in compliance with Board Rule 108.

(20) **Form WC-102C. Attorney Leave of Absence.**

An attorney who is counsel of record, and wishes to obtain a Leave of Absence, must file this form with the Atlanta office of the Board. If granted, the leave will cover all cases for which the attorney is counsel of record which are not calendared on the date of approval.

(21) **Form WC-102D. Motion/Objection to Motion.**

A party who makes or objects to a motion shall use this form, if no other specific Board form exists for the motion or request, and shall serve a copy on all counsel and unrepresented parties.

(22) **Form WC-104. Notice to Employee of Medical Release to Return to Work with Restrictions or Limitations.**

For non-catastrophic accidents occurring on or after July 1, 1992, the employer/insurer shall send this form to the employee no later than 60 days after the medical release of the employee to return to work with restrictions or limitations.

(23) **Form WC-108a. Attorney Fee Approval.**

An attorney shall file this form in order to request approval of a fee contract, an assessed fee by consent, and for resolution of a fee lien dispute by consent, when there is no pending litigation, and shall serve a copy on all counsel and unrepresented parties.

(24) **Form WC-108b. Attorney Withdrawal/Attorney Fee Lien.**

An attorney who is terminated or wishes to withdraw must file this form and follow the procedures set out in Rule 108(d)-(e). An attorney of record who chooses to file a lien for services and/or request for reimbursement of expenses after withdrawal from representation or after services are terminated, in writing, by a client, shall file this form with supporting documentation, and serve a copy on all counsel and unrepresented parties.

(25) **Form WC-121. Change of TPA Claims Office/Servicing Agent.**

An insurer, self-insurer, or self-insurance fund shall file this form to give: 1) notice of the employment of a claims office; 2) change an address of a claims office; 3) add additional claims offices; and 4) notice of the

termination of services of a claims office.

(26) **Form WC-131. Permit to Write Insurance.**

Insurers shall complete this form and file it with the Board to receive a permit to write workers' compensation insurance in the state of Georgia.

(27) **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.

(28) **Form WC-200a Change of Physician/Additional Treatment by Consent.**

Parties who agree on a change of physician/additional treatment shall file a properly executed Form WC-200a with the Board, with copies provided to the named medical provider(s) and parties to the claim, which form shall be deemed to be approved and made the order of the Board pursuant to O.C.G.A. § 34-9-200(b) unless otherwise ordered by the Board. A Form WC-200a shall be rejected by the Board if a Form WC-1 or WC-14 has not been previously filed by any party or attorney creating a Board claim.

(29) **Form WC-200b. Request/Objection for Change of Physician or Additional Treatment.**

A party who requests a change of physician or additional treatment without consent, or who objects to a request which has been made, shall file this form with the Board, and serve a copy on all counsel and unrepresented parties. Objections must be filed within 15 days of the date on the certificate of service on the request.

(30) **Form WC-205. Request for Authorization of Treatment or Testing by Authorized Medical Provider.**

Authorized medical providers seeking approval for treatment or testing shall send this form by facsimile or e-mail directly to the insurer/self-insurer who must fax or e-mail a response within five business days. Neither the request nor response shall be filed with the Board, unless otherwise requested.

(31) **Form WC-206. Reimbursement Request of Group Health Insurance Carrier/Healthcare Provider.**

A group health insurance carrier or health care provider which requests reimbursement of medical expenses shall file this form during the pendency of a claim and serve a copy on all counsel and unrepresented parties.

(32) **Form WC-207. Authorization and Consent to Release Information.**

Employer/insurers seeking the release of medical information pursuant to O.C.G.A. § 34-9-207 may utilize this form to receive consent from the employee.

(33) **Form WC-208a. Application for certification of WC/MCO.**

(34) **Form WC-226(a). Petition for Appointment of Temporary Conservatorship of Minor.**

A party petitioning for the Board to appoint a temporary conservator to receive and administer workers' compensation benefits for a minor may file this form with the WC-14 or when submitting a settlement agreement and shall serve a copy on all counsel and unrepresented parties.

(35) **Form WC-226(b). Petition for Appointment of Temporary Conservatorship of Legally Incapacitated Adult.**

A party petitioning for the Board to appoint a temporary conservator to receive and administer workers' compensation benefits for a legally incapacitated adult may file this form with the WC-14 or when submitting a settlement agreement and shall serve a copy on all counsel and unrepresented parties.

(36) **Form WC-240. Notice to Employee of Offer of Suitable Employment.**

The employer/insurer shall use this form to notify an employee of an offer of employment which is suitable to his/her impaired condition as required by O.C.G.A. § 34-9-240, and shall provide it to the employee and his/her attorney at least 10 days prior to the date the employee is scheduled to return to work. File this form as an attachment to a Form WC-2 when unilaterally suspending income benefits under Board Rule 240.

(37) **Form WC-240A. Job Analysis.**

An employer/insurer may use this form in conjunction with a Form WC-240 to provide a detailed job description when notifying an employee of an offer of employment which is suitable to his/her impaired condition as required by O.C.G.A. §34-9-240, and shall provide it to the employee and his/her attorney at least 10 days prior to the date the employee is scheduled to return to work. Attach this form with a Form WC-240 and file it with the Form WC-240 as an attachment to a Form WC-2 when unilaterally suspending income benefits under Board Rule 240.

(38) **Form WC-243. Credit.**

An employer/insurer seeking a credit pursuant to O.C.G.A. § 34-9-243 shall file this with the Board and send a copy to all counsel and unrepresented parties. The employer/insurer must specify the amount of unemployment compensation and/or income payments made to the employee pursuant to a disability plan, a wage continuation plan, or a disability insurance policy, and shall specify the ratio of the employer's contributions to the total contributions of such plan or policy.

(39) **Form WC-244. Reimbursement Request of Group Insurance Carrier/Disability Benefits Provider.**

A group insurance carrier or disability benefits provider which requests reimbursement of disability benefits shall file this form during the pendency of a claim, and serve a copy on all counsel and unrepresented parties.

(40) **Form WC-262. Payment of Temporary Partial Disability Income Benefits.**

Upon payment of any temporary partial disability income benefits under O.C.G.A. §34-9-262 to an employee based on an actual return to work, an employer shall file this form with the Board and send a copy to the employee and counsel, if represented.

(41) **Form WC-Change of Address.**

This form is to be used only to change certain addresses of record. For employers and attorneys, this form only needs to be filed once as this form will change information in every claim. Do not file this form if a party's

address is correct, but improperly listed in a claim.

(42) **Form WC-PMT**.

Use this form to request approval of recommended medical treatment or testing by an authorized medical provider.

(43) **Form WC-PMT(b).**

Use this form to request an employee to attend an appointment with an authorized medical provider.

(44) **Form WC-Request to Change Information.**

File this form to correct the employee's name, date of birth, correct the county of injury and to correct a claims office that has been listed incorrectly in a claim. (This form can be filed by any party.)

(45) **Form WC-R1. Request for Rehabilitation.**

The employer/insurer shall file:

(A) Within 48 hours of the employer's acceptance of a catastrophic injury as compensable, simultaneously with the Form WC-1, naming a catastrophic supplier;

(B) Within 15 days of notification that rehabilitation is required to request a rehabilitation supplier;

(C) When the employer/insurer requests a supplier for cases with dates of injury prior to July 1, 1992;

(D) When the employer/insurer requests a change of supplier;

(E) To request reopening of rehabilitation; or

(F) Upon request of the Board.

The employee or employee's attorney shall file a Form WC-R1 to request appointment of a supplier for cases with dates of injury prior to July 1, 1992, for change of supplier or reopening of rehabilitation.

A case party shall file a Form WC-R1 when a stipulated settlement provides for rehabilitation and rehabilitation is not already on the case. A case party may file a Form WC-R1 to request an extension of vocational rehabilitation services for cases with dates of injury prior to July 1, 1992.

All required information shall be supplied and shall be legible. The certificate of service must be completed and the date mailed must be indicated.

(46) **Form WC-R1CATEE. Employee Request for Catastrophic Designation.**

The employee or employee's attorney shall file:

(A) If the employer/insurer fail to timely designate the claim catastrophic and the employee believes the case to qualify for catastrophic designation;

(B) With supporting documentation;

(C) Presenting a choice for a Board Certified catastrophic rehabilitation supplier.

(47) **Form WC-R2. Rehabilitation Transmittal Report.**

The principal rehabilitation supplier shall file:

(A) To accompany updated narrative progress reports on

catastrophic cases every 90 days;

(B) To prepare for a rehabilitation conference;

(C) Progress reports as required by the Board not submitted with a Form WC-R2A and when a stipulation request has been submitted;

(D) Upon request of the Board;

(E) To report medical care coordination services for non-catastrophic cases with dates of injury prior to July 1, 1992.

(48) **Form WC-R2A. Individualized Rehabilitation Plan.**

The principal rehabilitation supplier shall file within 90 calendar days from the date of appointment; not later than 30 calendar days prior to the end of the current rehabilitation period to request extension of services, or to amend an approved plan 30 calendar days prior to the date of plan expiration.

(49) **Form WC-R3. Request for Rehabilitation Closure.**

The principal rehabilitation supplier shall file this form, accompanied by a closure report and any necessary documentation:

(A) Following 60 days of return to work status;

(B) When further services are not needed or feasible;

(C) When a stipulated settlement has been approved by the Board that does not include further rehabilitation services; or

(D) When the Board has closed the case any party may file to request closure of rehabilitation accompanied by documentation supporting the request.

(50) **Form WC-R5. Request for Rehabilitation Conference**.

Any party or principal rehabilitation supplier may file to request a rehabilitation conference.

(51) **Form WC-Rehabilitation Registration Application. Application to be a licensed rehabilitation supplier.**

File this form with the Board to be a certified rehabilitation supplier in the state of Georgia.

(52) **Form WC-Rehabilitation Registration Application Renewal. Application to renew certification for a licensed rehabilitation supplier.**

File this form annually with the Board to renew certified rehabilitation supplier status in the state of Georgia.

(53) **Form WC-Catastrophic Rehab Release.**

To be utilized only by employers/insurers contracted with a Board Certified Managed Care Organzation. *See* Board Rule 201

(54) **Form Rehab Obj.**

Any party who has an objection to any issue related to rehabilitation services must timely file this form with supporting documentation attached. Timely filing is within 20 days of the certificate of service of a WC-R1; WC-R1CATEE; WC-R2; WC-R2A; or WC-R3.

(55) **Form WC-P1. Panel of Physicians. See Board Rule 201.**

(56) **Form WC-P3. WC/MCO Panel.**

To be utilized only by employers/insurers contracted with a Board Certified Managed Care Organization. *See* Board Rule 201.

(57) **Form WC-Bill of Rights. Bill of Rights**.

Use and post with the panel of physicians (Form WC-P1 or WC-Form P3). *See* O.C.G.A. §34-9- 81.1 & Board Rule 81.1.

(58) **Form WC-Subpoena**.

Use this form for hearings. Do not file subpoenas with the Board. Subpoenas shall be produced at the hearing or attached to a motion only when enforcement or a postponement is at issue.

(59) Any party or attorney filing a form with the Board shall use the most current version of the form. In addition, no party or attorney shall submit any form that has been discontinued or altered. A violation of this rule may result in the rejection of the filing with the Board, and/or the imposition of a civil penalty under O.C.G.A. §34-9-18.

(60) When electronically filing any form with the Board, and when required by Statute, Rule, or form to serve a copy on an opposing attorney or party, a copy of the form or the ICMS equivalent of the form filed may be used for service.

(61) Service upon a party or attorney of any form, document, or other correspondence shall be by electronic mail. Whenever electronic mail is not available, service shall be by U.S. Mail.

(62) All forms, documents, or other correspondence should be filed electronically through ICMS web submission or EDI, if available.

(63) No party or attorney shall use the ICMS doc-type "Misc" when requesting any action by the Board. This doc-type shall only be used when no action is being requested.

(64) A pro-se party must file correspondence, documents or forms in paper with any Board office. A document may be filed via facsimile transmission. Any filing by facsimile transmission must be clearly labeled with the name of the claimant, claim number, and Board division or employee to whom the facsimile transmission is directed.

Rule 62. Electronic Data Interchange (EDI).

(1) Filing with the Board:

(a) Prior to filing in EDI, insurers, self-insurers, group self-insurers, and designated claims offices (TPAs) must submit all required trading partner documents and be approved to file via EDI by the Board.

(b) Insurers, self-insurers, group self-insurers, or designated claims offices (TPAs) may file Forms WC-1, WC-2, WC-2a, WC-3 and WC-4 via EDI in form of FROIs (First Report of Injury) and SROIs (Subsequent Report of Injury).

(c) When suspending benefits via EDI and an attachment to a filing or submission is required such as a medical report, or WC-240, the employer, insurer, shall mail to, or electronically file with the Board the required attachment prior to or simultaneously with the filing of the appropriate EDI transaction.

(d) Pleadings, forms, documents, or other filings shall be filed with the Board electronically through ICMS or EDI, unless otherwise authorized in these Rules. However, in the event of an outage preventing an electronic submission and the

time for filing is at issue, the document may be filed in paper or by facsimile with any Board office. Any filing by facsimile transmission must be clearly labeled with the name of the claimant, claim number, and Board division or employee to whom the facsimile transmission is directed. The certificate of service, showing concurrent service upon the opposing party electronically or by facsimile transmission shall be a part of any electronic or facsimile transmission. Failure to include a certificate of service shall invalidate the filing. All facsimile transmissions must be identical to the originals and must be legible. The Board, within its discretion, may transmit documents by facsimile or electronic transmission.

(2) Changes in Handling of Claims:
If an insurer, self-insurer, or group self-insurer adds, replaces, or terminates the services of a claims office, per Rule 121, the trading partner agreement shall be immediately amended and updated.

(3) Compliance:
Insurers, self-insurers, group self-insurers, and claims offices must send valid data for names, addresses, dates of birth, dates of injury, and all other information required per the GA SBWC R3.0 Element Requirement Table. The Board has discretion to temporarily or permanently suspend the ability to file claims via EDI for any insurer, self-insurer, group self-insurer, or claims office who consistently reports incorrect and invalid data.

(4) Exceptions:
Upon request, or on its own, the Board, in its discretion, may grant exceptions to this rule.

Rule 63. Proration of Board's Expenses.

The premium to be reported to the Board for the purpose of assessment shall be the “direct net earned premium”. The minimum assessment based upon the administrative cost necessary to provide licensure support and basic computer management reports shall be $200 annually for each insurer and self-insurer.

Rule 81.1. Bill of Rights.

The employer shall post the summary of rights, benefits, and obligations which is required by O.C.G.A. § 34-9-81.1 and is provided by the Board in the same location as the panel of physicians which is required by O.C.G.A. § 34-9-201.

Rule 82. Statute of Limitation and Procedure for Filing Claims.

(a) Any defense as to the time of filing a claim is waived unless it is made no later than the first hearing.

(b) A party filing a claim should file Form WC-14 with the Board and serve a copy on all other parties.

(c) A claim shall be filed electronically through ICMS. However, in the event of an outage preventing an electronic submission and the time for filing a claim is at issue, a claim may be filed in paper or by facsimile with any Board office. Any filing by facsimile transmission must be clearly labeled with the name of the claimant, claim number, and Board division or employee to whom the facsimile transmission is directed.

Rule 84. Payment of Loans or Assignments to Third-Party Creditors

No party to a claim or any party's attorney shall assist, secure, create, or execute any loan or assignment with a third-party creditor which requires repayment out of any recovery, settlement, or payment of benefits from any claim filed under this chapter. A third-party creditor shall not include a medical provider who has provided reasonable and necessary medical services to the employee pursuant to the fee schedule.

Rule 100. Alternative Dispute Resolution (ADR) Division.

(a) An Alternative Dispute Resolution Division is established to resolve disputes without the necessity of a hearing.

(b) Hearing requests or motions will be screened in order to identify cases likely to be resolved by Board order or the mediation process without a hearing.

(c) In addition, the ADR Division and each Administrative Law Judge shall have the authority to direct the parties to attend a mediation conference when deemed appropriate by the Board. The Board's authority to direct the parties to attend a mediation conference shall extend to include mediation of disputes which arise in cases designated as "Medical Only." Participation in a mediation conference shall not abridge the rights of the parties to a subsequent evidentiary hearing or ruling on the contested issues should the issues not be successfully resolved through mediation. An expedited hearing may be scheduled by agreement of the parties subsequent to the conference being held. An agreement reached at mediation will be reduced to writing and shall have the full effect of an award or order issued by the Board. A settlement agreement reached through the mediation process must be submitted and reviewed pursuant to O.C.G.A. § 34-9-15 and Board Rule 15.

(d) Parties requesting a Board mediation for the purpose of an all issues settlement must file a Form WC-100 certifying that all parties are in agreement with the request for a settlement mediation and that the employer/insurer has, or will have by the date of the first scheduled mediation conference, authority to resolve the claim based upon a good faith evaluation. The Form WC-100 must be served on all parties and parties at interest simultaneous with the board filing.

(e) Notices of Mediation will be sent by electronic mail and shall only be sent to attorneys of record. Whenever electronic transmission is not available, a Notice of Mediation will be sent by mail.

(f) Communications

(1) All communications or statements, oral or written, that take place within the context of a mediation conference are confidential and not subject to

disclosure. Such communications or statements shall not be disclosed by any mediator, party, attorney, attendee, or Board employee and may not be used as evidence in any proceeding. An executed Board mediation sheet or written executed agreement resulting from a mediation is not subject to the confidentiality described above.

(2) Neither the mediator nor any 3rd party observer present with the permission of the parties may be subpoenaed or otherwise required to testify concerning a mediation or settlement negotiations in any proceeding. The mediator's notes shall not be placed in the Board's file, are not subject to discovery, and shall not be used as evidence in any proceeding.

(3) Confidentiality does not extend to:

(A) threats of violence to the mediator or others;

(B) security personnel or law enforcement officials;

(C) party or attorney misconduct;

(D) legal or disciplinary complaints brought against a mediator or attorney arising out of and in the course of a mediation;

(E) appearance;

(F) the list of physicians submitted to an Administrative Law Judge by the parties or attorneys when the parties have been ordered to submit the names of physicians in a change of physician dispute and the dispute is not resolved through mediation.

(g) Attendance

(1) Each party to the dispute is required to have in attendance at the mediation conference a person or persons who have adequate authority to resolve all pending issues. The employee shall be in attendance at the mediation conference. The employer shall have in attendance at the mediation conference a representative of the employer/insurer who has authority to resolve all pending issues. The requirement of the presence of the employer/insurer's representative shall not be satisfied by the presence of legal counsel of the employer. In claims where the Subsequent Injury Trust Fund (SITF) is a party-at-interest to the claim, a representative of the SITF must either be in attendance at the mediation conference or have extended settlement authority to the representative of the employer/insurer no later than two business days prior to the date of the conference. Exceptions to the attendance requirement may be granted upon permission of an Administrative Law Judge from the ADR Division or his/her designee, obtained prior to the conference date.

(2) Only the parties and attorneys of record may attend a scheduled mediation. Exceptions to attendance may be granted if agreed or consented to by the parties and attorneys of record and approved by a mediator or an Administrative Law Judge.

(h) (1) Any party or attorney directed or ordered by the Board to participate in or attend a mediation conference and who fails to attend the scheduled conference without reasonable grounds may be subject to civil penalties, attorney's fees, and/ or costs. If the parties or attorneys agree to the postponement and/or rescheduling of a mediation conference, such request may be granted at the discretion of an Administrative Law Judge from the

ADR Division or his/her designee upon good cause shown. Any party or attorney requesting cancellation, postponement or rescheduling of a mediation conference shall provide notice to all parties or their attorneys and shall promptly, but in no event later than 2:00 p.m. on the business day immediately before the scheduled mediation conference, notify the ADR Division of the request: (1) first, by telephone call; and (2) if so instructed by the ADR Division, by subsequent written or electronic confirmation.

(2) Whenever the pending mediation issues resolve or a case settles prior to a scheduled mediation date, the parties or attorneys shall immediately notify the ADR Division: (1) first, by telephone call; and (2) if so instructed by the ADR Division, by subsequent written or electronic confirmation.

(3) Any party or attorney who fails to follow the cancellation, postponement, or rescheduling procedures as outlined above in sections (h) (1) & (2), and who is unable to show good cause for such failure, may be subject to civil penalties, assessed attorney's fees, and/or costs.

(4) The ADR Division may postpone, reset, cancel, or take off the calendar any mediation request, scheduled mediation, or Board ordered mediation.

(i) No person shall, during the course of a claim, engage in any discourteous, unprofessional, or disruptive conduct.

Rule 102. Attorneys Entitled to Practice Before the Board; Reporting Requirements; Postponements, Leave of Absence, and Legal Conflicts; Conduct of Hearings; Motions and Interlocutory Orders; Discovery and Submission of Evidence; Written Responses.

(A) Practice of Law:

(1) Attorneys Entitled to Practice before the Board: The Rules and Regulations for the Organization and Government of the State Bar of Georgia, as now in effect or as hereinafter amended, are controlling as to the practice of law before the Board and its Administrative Law Judges. The Board and its administrative law judges shall comply with the Code of Judicial Conduct.

(2) Any ex parte communication, including electronic mail, with an Administrative Law Judge or the Board in a pending claim is prohibited.

(3) Attorneys, not licensed in the State of Georgia, shall comply with Uniform Rule of Superior Court 4.4 addressing Admission Pro Hac Vice.

(4) On all filings with the Board, attorneys shall place their Georgia bar number. In addition, no attorney shall submit any form that has been discontinued or altered. A violation of this rule may result in the rejection of the filing with the Board, and/or the imposition of a civil penalty under O.C.G.A. §34-9-18.

(5) Service upon a party or attorney of any form, document, or other correspondence shall be by electronic mail. Whenever electronic mail is not available, service shall be by U.S. Mail.

(6) No party shall make any audio, video, photographic, electronic recording or court transcription of a Board proceeding, including any conference call with an Administrative Law Judge, unless expressly permitted

by the Board. Any such request must be submitted to the Board at least 24 hours prior to proceeding or conference call with notice to all parties. This Rule does not apply to an official function of a law enforcement agency, the State Bar of Georgia, or the Judicial Qualifications Commission.

(B) Reporting Requirements:

(1) The address of record of an employee shall be that address shown on the most recent document filed with the Board.

(2) A party shall provide notice to the Board of the intent to obtain legal representation and the name of its legal representative, if any, within 21 days from the date of the hearing notice, subject to an assessment of penalties for failure to comply.

(3) The address of record of an employer shall be the address shown on the Form WC-1, the address on file with a Licensed Rating Organization filed by the insurer on behalf of the employer, or the principal office of the employer within the State of Georgia.

(4) Any party requesting a hearing shall furnish the correct name, current address, and phone number if available, of the employee, the employer, and the insurer/self insurer at the time the hearing is requested.

(5) An attorney who represents a party other than an employee or a claimant in a contested matter must file a notice of representation on a Form WC-102B with the Board and must serve a copy on all counsel and unrepresented parties.

(6) An attorney who represents an employee or claimant in a contested matter shall file a fee contract as notice of representation and must serve a copy on all counsel and unrepresented parties. The contract must be dated, conform to Rule 108, and both the attorney and the client must sign the contract.

(C) Postponements, Leaves of Absence, and Legal Conflicts:

(1) (a) Postponement: If a hearing is on a calendar for the first time, and if all parties agree to postpone it to be rescheduled, they may obtain the postponement without consulting the Administrative Law Judge before whom it is scheduled, absent prior specific instructions from the judge to the contrary. This agreement must be communicated to the judge no later than 2:00 p.m. of the business day immediately preceding the hearing by the party who requested the hearing, or by any other party by agreement. Otherwise and generally, a hearing shall be postponed only upon strict legal grounds, or at the discretion of the Board or an Administrative Law Judge. For a case that has already been postponed, a second or subsequent request by counsel to postpone the case from a calendar must be made no later than 2:00 p.m. on the business day immediately before the scheduled hearing, and the request must be approved by the Administrative Law Judge. For a case to be removed from the calendar with no reset, this notification, as with a postponement request, must be made no later than 2:00 p.m. on the business day immediately before the scheduled hearing. If the judge determines that the case is not ready for

trial at this time, the claim may be removed from the calendar, not to be reset until the parties certify that discovery is complete and the case is ready to be tried. Consistent with O.G.C.A. §34-9-102(a) and (c), a postponed hearing shall not be scheduled less than 30 days nor more than 90 days from the date of the hearing notice, unless agreed upon by the parties, in which case it may be scheduled for a shorter or longer period.

(b) Whenever the pending hearing issues resolve or a case settles prior to a scheduled hearing date, the parties or attorneys shall immediately notify the Board or assigned Administrative Law Judge: (1) first, by telephone call; and (2) if so instructed by the Trial Division, by subsequent written or electronic confirmation.

(c) Any party or attorney who fails to follow the cancellation, postponement, or rescheduling procedures as outlined above in sections (C)(1) (a) & (b), and who is unable to show good cause for such failure, may be subject to civil penalties, assessed attorney's fees, and/or costs, including but not limited to the cost of the court reporter. If the parties fail to communicate with the Administrative Law Judge whether a scheduled hearing is going forward by 2:00 p.m. on the business day immediately preceding the hearing, the Administrative Law Judge may leave the case on the calendar for a hearing or postpone and reset the case to a future calendar.

(2) Leave of absence. In the event that an attorney wishes to obtain a leave of absence from the Board, the request should be submitted on a Form WC-102C and mailed to the Atlanta office of the State Board of Workers' Compensation or filed on-line via ICMS. The granting of a leave of absence will not apply to cases already calendared on the date the leave is signed and will apply only to court appearances and mediations. In the event that leave is requested for a date already calendared, the attorney must request a postponement from the Administrative Law Judge, with permission of opposing counsel or by conference call, prior to the hearing or mediation.

(3) For the purpose of resolving requests for continuance based upon legal conflict, Rule 17.1(B)(4) of the Uniform Rules of the Superior Courts shall apply. A conflict letter shall be served upon opposing counsel and unrepresented parties no later than seven days prior to the date of conflict but shall not be filed with the Board unless or until such conflict letter is requested by an Administrative Law Judge or the Board. The action which was first filed shall take precedence, subject to judicial discretion.

(D) Motions and Interlocutory Orders Pending a Hearing:

(1) (a) All motions and objections shall be made on Form WC-102D, with the exceptions of motion for reconsideration and request for a change of physician/additional medical treatment under Board Rule 200(b)(1). Motions and objections, including briefs and exhibits, shall be limited to 50 pages, unless otherwise approved by an Administrative Law Judge or the Board. When attaching documents as evidence to motions and objections, do not use tabs to separate documents. Any party or attorney filing a motion or

objection shall also serve a copy on all counsel and unrepresented parties, along with supporting documents, including a separate certificate of service identifying the names and addresses served.

(b) When filing a motion for reconsideration, the parties or attorneys shall:

(1) immediately notify the Board or assigned Administrative Law Judge by telephone call; (2) use the ICMS doc-type labeled motion for reconsideration; (3) limit their motion to 20 pages, including briefs and exhibits, unless otherwise permitted by the Board or an Administrative Law Judge; and (4) serve a copy on all counsel and unrepresented parties, along with supporting documents, including a separate certificate of service identifying the names and addresses served.

(2) Prior to filing a motion, including requests for documents made pursuant to Rule 102(F)(1), the moving party shall confer with the opposing party, or counsel if the party is represented, in a good-faith effort to resolve the matters involved.

(3) A party objecting to a motion shall respond on a Form WC-102D, which must be filed with the Board within 15 days of the date of the certificate of service on the request, and shall serve a copy on all counsel and unrepresented parties.

(4) Whenever the pending issues resolve, in whole or in part, or at any time that a ruling on a motion is no longer necessary or desired, the parties or attorneys shall immediately notify the Board or assigned Administrative Law Judge: (1) first, by telephone call; and (2) if so instructed, by subsequent written or electronic confirmation. Any party or attorney who fails to follow this procedure, and who is unable to show good cause for such failure, may be subject to civil penalties and/or assessed attorney's fees.

(5) An Administrative Law Judge may issue an interlocutory order suspending or reinstating payment of weekly benefits to an employee pending an evidentiary hearing.

(6) Where the issue is which of two or more employer/insurers is liable, the Administrative Law Judge or the Board may issue an interlocutory order directing the employer or one of the insurers to pay weekly benefits and medical expenses until the determination of liability of an insurer has been made. Reimbursement may thereafter be ordered where appropriate.

(E) Conduct of Hearings:

(1) No person shall, during the course of a proceeding, where a hearing has been requested, engage in any discourteous, unprofessional, or disruptive conduct.

(2) Any violation of the Georgia Rules of Professional Conduct of the State Bar of Georgia may subject an attorney to the assessment of a civil penalty pursuant to OCGA §34-9-18 and referral to the State Bar of Georgia for disciplinary action.

(3) (a) Prior to the commencement of a hearing, the parties shall consolidate any and all records, including but not limited to medical records, and any other documentary evidence to be admitted at a hearing in order to

avoid any repetition and duplication.

(b) All medical evidence regarding the treatment, testing or evaluation of the claimant for the accident which is the subject of the hearing should be exchanged between the parties as soon as practicable, but no later than ten days prior to the hearing, and all depositions should be completed prior to the hearing. Failure to exchange such evidence within ten days of a hearing may, in the discretion of the Administrative Law Judge or the Board, result in: (1) the imposition of civil penalties, (2) award of assessed attorney fees, (3) a continuance,(4) award of costs, (5) award of witnesses fees and expenses, and/or (6) in limited circumstances, the exclusion of evidence at the hearing.

(c) If the amount of the average weekly wage is in dispute, counsel shall exchange written contentions with respect to their methods of calculation at least ten days prior to the hearing, and shall present the written contentions to the Administrative Law Judge at the commencement of the hearing.

(d) If accompanied by an affidavit, a written laboratory test result report is admissible into evidence for purposes of authenticity only. Any other evidentiary objections can be raised by the parties in motions or at evidentiary hearings.

(e) Any challenge to the testimony of an expert under O.C.G.A. § 24-9-67.1 (24-7-702 effective 1/1/13) shall be made not later than 15 days prior to the hearing. Failure to raise a timely challenge shall result in waiver of the challenge unless otherwise agreed to by the attorneys and the Administrative Law Judge.

(4) Parties may be allowed to make arguments either by the filing of briefs within the time set by the Administrative Law Judge at the hearing, by oral argument at the conclusion of the presentation of evidence at the hearing, or both.

Oral argument shall be limited to five minutes for each party. Briefs shall be limited to 30 pages, unless otherwise approved by an administrative law judge or the Board.

(5) It is the policy of the Board to encourage the parties to close the record at the conclusion of the hearing. The parties are expected to make diligent efforts to present all the evidence at the hearing, without the need for the record to remain open.

(6) Hearing Transcript: Any Administrative Law Judge is authorized to relieve the court reporter of the duty of transcribing the record of proceedings. The record shall be transcribed and submitted to the Board or the superior court if there is an application for review of an appeal. The appellant shall serve a copy of the application for review or appeal on the court reporter at the same time it is served on all other persons.

(7) Notices of hearing may be sent by electronic mail to the parties and attorneys of record. Whenever electronic transmission is not available, a notice of hearing will be sent by U.S. Mail.

(8) The usage and enforcement of subpoenas shall be governed by O.C.G.A. §24-10-1 *et seq*. (24-13-1 effective 1/1/13), except subpoenas

shall not be filed with the Board. Subpoenas shall be produced at the hearing or attached to a motion only when enforcement or a postponement is at issue.

(F) Discovery and Submission of Evidence:

(1) Prior or subsequent to a request for hearing being filed in a claim, the parties shall be entitled to receive from each other without cost the documents specified in Form WC-102. These documents shall be provided within 30 days of the date of the certificate of service. Neither the request nor response shall be filed with the Board. Any party or attorney who fails to follow this procedure, and who is unable to show good cause for such failure, may be subject to civil penalties and/or assessed attorney's fees.

(2) Discovery conducted pursuant to the Civil Practice Act shall only be permitted while a hearing is pending in the claim, or as otherwise specified in these rules, or by agreement of the attorneys or as permitted by an Administrative Law Judge or the Board.

(3) Discovery documents, including but not limited to depositions, interrogatories, and notices to produce, shall not be filed with the Board until such time as they are tendered in evidence in a proceeding before the Board. Correspondence between the parties shall not be filed with the Board.

(4) All documents, transcripts, exhibits, and other papers filed with the State Board of Workers' Compensation shall be submitted on 8-1/2 by 11-inch paper only. Sufficient space shall be left at the top of all documents (at least one and one-half inches) so that all information will remain readable after the documents have been filed. Copies of items offered in evidence at a hearing must be properly identified and tendered to opposing parties at the hearing. When submitting any documents as evidence, do not use tabs to separate documents.

(G) Written Responses: The filing of all written responses will be governed in accordance with O.C.G.A. §9-11-6(e).

Rule 102.1. Practice of Law before the Board.

(a) Attorneys in good standing admitted to practice in the State of Georgia, shall file, sign, and verify documents only by electronic means via ICMS. Only an electronic submission of documents via ICMS shall constitute filing, except as provided for in sections (i) and (j) or as otherwise provided in the Board Rules.

(b) Pro se litigants who are not attorneys in good standing with the State Bar of Georgia must file all documents with the Board in paper form with any Board office.

(c) The electronic filing of any document, form, or other correspondence by an attorney who is a registered participant in ICMS shall constitute the signature of that attorney under Board Rule 60(g) and O.C.G.A. §10-12-2 *et seq*. The attorney whose login and password are used to accomplish an electronic filing certifies that the attorney and the attorney's law firm have authorized the filing.

(d) No attorney shall knowingly permit or cause to permit his/her login or password to be used by anyone other than an authorized employee of his/her law firm.

(e) No person shall knowingly use or cause another person to use the login or password of a registered attorney unless such person is an authorized employee of the law firm.

(f) Only the original of any form, document, or other correspondence shall be electronically filed with the Board. Duplicate originals shall not be filed with the Board. Where providing a courtesy copy in response to a request from an Administrative Law Judge or the Board, that document shall be identified clearly and prominently as a courtesy copy.

(g) When electronically filing any form with the Board, and when required by Statute, Rule, or form to serve a copy on an opposing attorney or party, a copy of the form or the ICMS equivalent of the form filed may be used for service.

(h) Service upon a party or attorney of any form, document, or other correspondence shall be by electronic mail. Whenever electronic mail is not available, service shall be by U.S. Mail.

(i) ICMS will be available during the Board's business hours of 8:00 a.m. through 4:30 p.m., Monday through Friday, except state holidays. Known systems outages will be posted on the web site, and communicated by email, if possible. In the event of an outage preventing an electronic submission and the time for filing a document is at issue, the document may be filed in paper or by facsimile with any Board office. Any filing by facsimile transmission must be clearly labeled with the name of the claimant, claim number, and Board division or employee to whom the facsimile transmission is directed.

(j) Proposed consent orders, petitions for guardianships via Form WC-226a and Form WC-226b, Form WC-14s adding additional parties, and Form WC-12s, are exempt from section (a) and may be filed in paper only with the Board in Atlanta, Georgia.

(k) Any filing, document, correspondence, or form filed with the Board that is not in compliance with this rule shall be rejected.

(l) Upon request, or on its own, the Board, in its discretion, may grant exceptions to this rule.

Rule 102.2 Policy for Electronic and Photographic News Coverage of Proceedings

Unless otherwise provided by rule of the State Board of Workers' Compensation or otherwise ordered by the assigned Judge after appropriate hearing (conducted after notice to all parties and counsel of record) and findings, representatives of the print and electronic public media may be present at and unobtrusively make written notes and sketches pertaining to any proceedings at the Board. In any event, said representatives are to provide the assigned Judge advanced notice of their intent to attend and to make such notes and sketches so the Judge may insure that they do not otherwise interfere with the proceedings. However, due to the inherent distractive nature of electronic or photographic equipment, representatives of the public media utilizing such equipment or seeking permission to do so are subject to the discretion of the Presiding Judge as well as the following restrictions and conditions;

(a) Persons desiring to broadcast/record/photograph proceedings must file a timely written request (form attached as Exhibit "A"), before the subject proceeding, with the judge involved and all parties of record to the hearing or trial, specifying the particular proceeding for which such coverage is intended; the type equipment to be used in the hearing room; the proceeding to be covered; and the person responsible for installation and operation of such equipment.

(b) Approval of the judge to broadcast/record/photograph a proceeding, if granted, shall be granted without partiality or preference to any person, new agency, or type of electronic or photographic coverage, who agrees to abide by and conform to these rules, up to the capacity of the space designated for the hearing room. Violation of these rules will be grounds for reporter/technician to be removed or excluded from the hearing room (and contempt proceeding initiated).

(c) The judge may exercise discretion and require pooled coverage which would allow only one still photographer, one television camera and attendant, and one radio or tape recorder outlet and attendant. Photographers, electronic reporters and technicians shall be expected to arrange among themselves pooled coverage if so directed by the judge and to present the judge with a schedule and description of the pooled coverage. If the covering persons cannot agree on such a schedule or arrangement, the schedule and arrangements for polled coverage may be designated at the judge's discretion.

(d) The positioning and removal of cameras and electronic devices shall be done quietly and if possible, before or after the hearing or during recesses; in no event shall such disturb the proceedings. In every such case, equipment should be in place and ready to operate before the time the hearing is scheduled to begin.

(e) Overhead lights in the hearing room shall be switched on and off only by board personnel no other lights, flashbulbs, flashes or sudden light changes may be used unless the judge approves beforehand.

(f) No adjustment of central audio system shall be made except by persons authorized by the Board. Audio recordings of the proceeding will be from one source, normally by connection to the central audio system. Upon prior approval of the Board, other microphones may be added in an unobtrusive manner to the public address system.

(g) All television cameras, still cameras and tape recorders shall be assigned to

specific portion of the public- area of the hearing room or specially designed access areas, and such equipment will not be permitted to be removed or relocated during the court proceedings.

(h) Still cameras must have quiet functioning shutters and advancers. Movie and television cameras and broadcasting and recording devices must be quiet running. If any equipment is determined by the judge to be of such noise as to be distractive to the proceedings, then such equipment can be excluded from the hearing room by the judge.

(i) Reporters, photographers, and technicians must have and produce upon request of Board officials' credentials identifying them and the media company for which they work.

(j) Proceedings shall not be interrupted by a reporter or technician with a technical or an equipment problem.

(k) Reporters, photographers, and technicians should do everything possible to avoid attracting attention to themselves. Reporters, photographers, and technicians will be accorded full right of access to proceedings for obtaining public information within the requirements of due process of law, so long as it is done without detracting from the dignity and decorum of the hearing.

(l) Other than as permitted by these rules and guidelines, there will be no photographing, radio or television broadcasting, including video taping pertaining to any proceedings on the floor where the hearing or proceeding is being held or any other floor whereon is located a hearing, whether or not the hearing is actually in session.

(m) No interviews pertaining to a particular proceeding will be conducted in the hearing room except with the permission of the judge.

(n) Upon receipt of request pursuant to exhibit "A" which is attached hereto, the board shall give notice to all parties involved in the case and field judges shall contact the administrator of the facility at which the proceeding is going to be held, if the proceeding is not scheduled to be held at a board facility, to determine that facilities rules or requirements with respect to the request and the granting of the request shall be, in addition to the judge's discretion, subject to that facility's administrator giving approval of the request.

(o) A request for installation and use of electronic recording, transmission, videotaping or motion picture or still photography of any proceeding shall be evaluated pursuant to the standards set forth in OCGA § 15-1-10.1.

EXHIBIT "A"
IN THE STATE BOARD OF WORKERS' COMPENSATION

(STYLE OF CASE) CASE NO.---
REQUEST TO INSTALL RECORDING AND/OR PHOTOGRAPHING EQUIPMENT PURSUANT TO POLICY AND GUIDELINES FOR ELECTRONIC AND PHOTOGRAPHIC NEWS COVERAGE OF STATE BOARD OF WORKERS' COMPENSATION PROCEEDINGS.
Pursuant to the State Board of Workers Compensation policy for Electronic and Photographic News Coverage of Proceedings the undersigned hereby requests permission to install equipment in ---------- hearing room in

order to photograph or televise all or portions of the proceedings in the above-captioned case.

Consistent with the provisions of the policy the undersigned desires to install the following described equipment: _____ in the following location:_____. The proceedings that the undersigned desires to record, photograph or televise commence on (date). Subject to direction from the Board regarding possible pooled coverage, the undersigned wishes to install this equipment in the hearing room on (date)_____. The personnel who will be responsible for the installation and operation of this equipment during its use are: (identify appropriate personnel).
The undersigned hereby certifies that the equipment to be installed and the locations and operation of such equipment will be in conformity with the policy and guidelines issued by the Board.

This ___ day of ___ 20--.

_____
(Individual Signature)

_____
Address

_____
Telephone Number

_____
(Representing/Firm)

_____
(Position)

APPROVED this __ day of ___, 20__

_____
State Board of Workers' Compensation

Rule 103. Appeals to the Appellate Division.

(a) The time for application for review commences on the date shown on the notice of award and is computed as in paragraph (3) of subsection (d) of O.C.G.A. § 1-3-1.
(b) Appearance before the Appellate Division shall be by brief only unless a request for oral argument is made at the time the application for review is filed by appeal or cross appeal. Within 10 days from the date of the certificate of service on the application for review, the appellee or cross appellee may request oral argument. Oral argument shall be limited to five minutes for each party.

(1) Any party applying for review shall serve a copy of the application for review and enumerations of errors allegedly made by the Administrative

Law Judge upon all opposing parties. Failure to file enumerations of error with the Board may result in the dismissal of the appeal or cross appeal.

(2) The party requesting review shall have 20 days from the date shown on the certificate of service of the application for review in which to file a brief. The party requesting the review shall certify that a copy of the brief was served in accordance with Rule 61(b)(61) to all opposing parties on the date the brief is submitted to the Board. Opposing parties shall then have 20 days from the date of appellant's or cross appellant's certificate of service to file reply briefs with the Board. Briefs not filed in conformity with this rule will not be accepted except by permission of the Board.

(3) Notices of Oral Argument, and other correspondence, will be sent by electronic mail and only to attorneys of record. Whenever electronic transmission is not available, a Notice of Oral Argument, or other correspondence, shall be sent by mail.

(4) Briefs shall generally follow the format required by the appellate courts. Only the original of the brief is required to be filed with the Board. Briefs shall be limited to 20 pages, unless otherwise approved by the Board.

(5) Where a case has been scheduled on a calendar for oral argument, no more than one postponement will be granted to reschedule the argument. If the argument cannot be made within that time, the claim may be reviewed on briefs only.

(6) Any party scheduled for oral argument shall notify the Appellate Division no later than 48 hours before the scheduled appearance if they do not intend to appear.

(7) Amicus curiae briefs may be filed without permission any time before a decision is issued. The amicus brief shall disclose the identity and interest of the person or group on whose behalf the brief is filed.

(8) In a pending appeal before the Appellate Division, whenever the issues resolve, in whole or in part, or a case settles, the parties or attorneys shall immediately notify the Court Clerk of the Appellate Division: (1) first, by telephone call; and (2) if so instructed by the Appellate Division, by subsequent written or electronic confirmation. Any party or attorney who fails to follow this procedure, and who is unable to show good cause for such failure, may be subject to civil penalties, assessed attorney's fees, and/or costs**.**

(9) When filing a motion for reconsideration, the parties or attorneys shall:

(1) immediately notify the Court Clerk of the Appellate Division or the Board by telephone call; (2) use the ICMS doc-type labeled motion for reconsideration; (3) limit their motion to 20 pages, including briefs and exhibits, unless otherwise permitted by the Court Clerk or the Board; and (4) serve a copy on all counsel and unrepresented parties, along with supporting documents, including a separate certificate of service identifying the names and addresses served.

(10) An appeal shall be filed electronically through ICMS. However, in the event of an outage preventing an electronic submission and the time for

filing an appeal is at issue, an appeal may be filed in paper or by facsimile with any Board office. Any filing by facsimile transmission must be clearly labeled with the name of the claimant, claim number, and Board division or employee to whom the facsimile transmission is directed.

(c) The Board will apply the law of Georgia regarding the tenure and character of newly discovered evidence required for the granting of a new trial.

(d) The Board will not accept an application for review of an interlocutory order unless the Administrative Law Judge, in the exercise of his or her discretion, certifies that the order or decision is of such importance to the case that immediate review should be had. In the event the Administrative Law Judge certifies his or her interlocutory order for immediate review, in order for the Appellate Division to have jurisdiction under O.C.G.A. §34-9-103(a), a party must file an application for review with the Appellate Division within twenty days of the date of the original interlocutory order.

(e) No person appearing before the Appellate Division shall engage in any undignified or discourteous conduct.

(f) Upon determining that an appeal has been prosecuted without reasonable grounds, the Appellate Division shall have the authority to assess penalties and attorneys' fees against the offending party.

Rule 104. Suspension/Reinstatement of Benefits. **

(a) To unilaterally convert the employee's income benefits from temporary total disability income benefits to temporary partial disability income benefits under O.C.G.A. §34-9-104(a)(2), the employer/insurer shall file a Form WC-104 with the Board and shall serve the employee and the employee's attorney the Form WC-104 no later than 60 days from the date the employee was released to work with restrictions by the employee's authorized treating physician. In addition, the employer/insurer shall attach to the Form WC-104 the supporting medical report from employee's authorized treating physician demonstrating the employee is capable of performing work with restrictions.

(b) After filing the Form WC-104 with the Board and serving the employee and the employee's attorney sufficient and timely notice under section (a), if the employee has been released to work with restrictions for 52 consecutive weeks or 78 aggregate weeks, the employer/insurer may unilaterally convert the employee's income benefits from temporary total disability income benefits to temporary partial disability income benefits by filing a Form WC-2 with the Board. Copies of all filings and supporting documents shall be served on the employee and the employee's attorney, if represented.

(c) Pursuant to Board Rule 60(c), all documents filed with the Board shall contain the employee's name, date of injury, and Board claim number. Any document that does not contain this information shall be rejected by the Board.

***The changes to Rule 104 requiring the filing of the Form WC-104 at the time the WC-104 is served on the employee and the employee's attorney shall not become effective until January 1, 2014.*

(d) The date that benefits may be converted from temporary total disability benefits to temporary partial disability benefits shall be determined by the date the employee was released to work with restrictions.

Rule 105. Appeals to the Courts.

(See O.C.G.A. §34-9-105 for additional details and instructions)

(a) Any party appealing from an award or order of the members of the Board shall file a petition for review with the proper Superior Court within 20 days of the date on the award or order. A copy of the petition for review shall simultaneously be filed electronically through ICMS, which satisfies the requirement that a copy of the petition be served on the clerk of the Board. The appealing party shall pay the reasonable copying and transmittal costs of the Board. Upon good cause shown, the Board may waive the copying and transmittal costs. The Board shall transmit certified copies of all documents and papers in its file together with a transcript of the testimony taken and its findings of fact and decision to the clerk of the Superior Court where the petition for review is filed. The Board will transmit the aforementioned documents within 30 days of receipt of the copy of the petition for review.

(b) In the event of an outage preventing an electronic filing of the copy of the petition for review in ICMS, a copy of the petition for review may be filed in paper or by facsimile with any Board office. Any filing by facsimile transmission must be clearly labeled with the name of the claimant, claim number, and Board division or employee to whom the facsimile transmission is directed.

(c) The party dismissing an appeal shall file a copy of the dismissal with the Board.

(d) In the event of a settlement during the pendency of an appeal, it shall be the joint obligation of the parties to supply the Board with copies of all documents necessary to restore jurisdiction to the Board to consider the settlement.

(e) The prevailing party shall supply the Board with copies of the following documents:

(1) Order of Superior Court disposing of an appeal;
(2) Denial by the Court of Appeals or Supreme Court of an application for discretionary review;
(3) Notice of appeal from Superior Court to Court of Appeals or Supreme Court where discretionary appeal is granted;
(4) Denial of certiorari by the Supreme Court from a decision of the Court of Appeals;
(5) Court of Appeals remittitur to Superior Court;
(6) Judgment on remittitur from Superior Court when the Court of Appeals does anything other than affirm the judgment of the Superior Court.

(f) The non-prevailing party shall supply the Board with copies of the following documents:

(1) Application to the Court of Appeals or Supreme Court for discretionary review of a judgment of the Superior Court;
(2) Application to the Supreme Court for certiorari to review a decision of the Court of Appeals;
(3) Notice from the Supreme Court of granting of certiorari from a decision of the Court of Appeals.

(g) Copies of the documents listed above shall be submitted to the Board electronically through ICMS or by regular mail within five days of filing in the appropriate court.

Rule 108. Attorney's Fees.

The attorney's fee shall not exceed 400 weeks of income benefits and may be terminated or suspended sooner as provided by law or at the Board's discretion. The Board may, in its discretion, approve an attorney's fee for a period of greater than 400 weeks so long as the attorney fee is not in excess of 25% of the claimant's weekly benefits.

(a) Attorney fee contracts.

(1) Immediately upon being employed by an employee or claimant in a matter which is before the Board, the attorney shall file a contract of employment and fees with the Board. No contract shall be filed with the Board which provides for a fee greater than 25 percent of the recovery of weekly benefits. Any contract with these terms, absent compelling evidence to the contrary, shall be deemed to represent the reasonable fee of the attorney.
(2) No party or any party's attorney shall enter into a loan or assignment with a third-party creditor which requires repayment from the proceeds of a workers' compensation claim. A third-party creditor shall not include a medical provider who has provided reasonable and necessary medical services to the employee pursuant to the fee schedule.

(3) The contract shall be dated and shall be signed by both the attorney and the client.
(4) This contract should include the following information: (1) name, (2) bar number, (3) firm name, (4) address, (5) phone number, (6) fax number, (7) email address, and (8) Board claim number. If the Board claim number is not known, this contract shall include the employee's first name, last name, date of injury, and should include the employee's address.
(5) This contract should include the following statement:
This contract is subject to the approval of the State Board of Workers' Compensation, and no fee of more than $100.00 shall be paid under the contract unless approved by the Board. No contract shall be filed with the Board which provides for a fee greater than 25 percent of the recovery of

weekly benefits. Any contract with these terms, absent compelling evidence to the contrary, shall be deemed to represent the reasonable fee of the attorney. No party or any party's attorney shall enter into a loan or assignment with a third-party creditor which requires repayment from the proceeds of a workers' compensation claim. A third-party creditor shall not include a medical provider who has provided reasonable and necessary medical services to the employee pursuant to the fee schedule.

An attorney who requests approval of his or her fee contract when there is no pending litigation shall file with the Board Form WC-108a. When an attorney requests approval of his or her fee contract after a hearing notice has been issued and after the dispute has been resolved, that attorney shall file Form WC-108a with the Administrative Law Judge who issued the hearing notice.

(b) (1) The value of the services of the attorney may be agreed upon by the parties subject to approval of the Board.

(2) Any offer to make payment if the party waives a claim for attorney's fees under paragraph (2) or (3) of subsection (b) of O.C.G.A. § 34-9-108, or any agreement to waive a claim for attorney's fees as a condition to payment of income or medical benefits, where the only consideration for such waiver is the commencement of income or medical benefits, shall be void *ab initio.*

(3) No party shall be required to pay an attorney for services for which the fee was assessed against the opposing party. The Board, if deemed appropriate, may approve an attorney's fee which combines fees assessed against an opposing party and fees paid pursuant to approval of an attorney fee contract, provided that the claimant receives a credit for the assessed fee.

(4) An attorney advertising to render services to a potential workers' compensation claimant must intend to render said services and shall not divide a fee with another attorney who is not a partner in or associate of his or her law firm unless:

1. The client consents to associating the other attorney after full disclosure that the fee will be divided; and,
2. The fee division is made in direct proportion to the services and responsibility performed and assumed by each attorney; and,
3. The total fee of the attorneys shall not exceed a reasonable fee for the claim.

No party shall be required to pay for the services of an attorney who violates the provisions of O.C.G.A. § 34-9-108(c).

(5) Upon assessing attorney's fees, costs may be assessed against the offending party which are payable to the Board in an amount not less than $250.00. The Administrative Law Judge may assess higher costs based on the length of the hearing, time traveled, and time lost from other duties. In any case where a determination is made that proceedings have been brought, prosecuted, or defended in whole or in part without reasonable

grounds, the Administrative Law Judge or the Board may, in addition to assessed attorney's fees, award to the adverse party reasonable litigation expenses, in whole or in part, against the offending party. Reasonable litigation expenses under this subsection are limited to witness fees and mileage pursuant to O.C.G.A. § 24-10-24 (24-13-24 effective 1/1/13); reasonable expert witness fees (subject to the Fee Schedule, where applicable); reasonable deposition costs; and the cost of the hearing transcript.

(6) When requesting payment of attorney's fees at a hearing pursuant to O.C.G.A. § 34-9-108, the party making the request shall be required to demonstrate the reasonableness of the attorney's fees requested by placing into the record expert testimony as to the value of services rendered. Counsel may testify personally or in affidavit form at the hearing, subject to cross-examination, as to expert status and the reasonable value of the services rendered in order to meet this requirement. No attorney's fees will be awarded pursuant to O.C.G.A. § 34-9-108 absent this evidence being placed in the record.

(7) When the parties agree to an assessment of attorney's fees, any attorney of record may file with the Board a Form WC-108a, serve a copy on all parties or their counsel, and sign the certificate of service on the form.

(8) An attorney shall not receive an attorney's fee on any medical treatment or expenses required for an employee, unless such fee is assessed under O.C.G.A. §34-9-108(b)(1).

(9) The Board shall not approve a percentage of the claimant's weekly benefits as an attorney fee unless the attorney sufficiently shows that the payment of weekly benefits is the result of the attorney's efforts.

(10) If an attorney obtains the "catastrophic" designation for a claim under O.C.G.A. §34-9-200.1(g), reinstates income benefits after a unilateral reduction under O.C.G.A. §34-9-104(a)(2), and/or prevents a change in condition, then, upon request, the Board may approve the attorney's fee contract to commence at such time as the benefit accrues to the claimant and if deemed appropriate by the Board.

(c) Solicitation of Services. See O.C.G.A. §§ 34-9-22, 34-9-30, 34-9-31 and 34-9-32.

(d) An attorney who has made an appearance by filing Form WC-14 or Form 102B or by filing a fee contract and who is terminated or wishes to withdraw as counsel for any party therein, shall file a Form WC-108b with the Board and serve a copy on all counsel and unrepresented parties, including the former client. At the time of withdrawal, the attorney shall provide all current contact information for the former client to the Board and all parties.

(e) An attorney of record who chooses to file a lien for services and/or expenses must do so by filing written notice of the contended value of such services and/or expenses with the Board on Form WC-108b within 20 days after (i) withdrawal from the case, or (ii) notice of termination of the contract in writing by the client. The attorney of record filing a lien shall serve a copy of Form WC-108b on all unrepresented parties and counsel. Failure to attach supporting documentation will result in the lien being denied. If the Board includes the issue of approval of the lien

for determination at a hearing or mediation, and the attorney who filed the lien fails to appear and present evidence in support of the lien, then it shall be void. If all parties agree to resolution of a lien request, then one of them must file with the Board Form WC-108a. Failure to perfect a lien in this manner will be considered a waiver of further attorneys' fees.

(f) No attorney shall charge to any client as an expense of litigation any portion of any referral fee or membership charged by any lawyer referral service, or nonspecific office costs.

Rule 121. Insurance in More Than One Company; Self-Insurance; Insurance by Counties and Municipalities.

(a) A compensation policy must cover all of the operations of an employer, except as hereinafter provided. 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.

(b) 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 employers 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.

(c) 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 therefore 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.

(d) 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 on a Form WC-121 (or annual update) of the name and address of each servicing agent or third party administrator handling Georgia claims, the name, address and telephone number of a contact person with that third party administrator or servicing agent, the effective date of the servicing agent's or third party administrator's commencement of services, and if applicable, the ending date of those services, and shall file Form WC-121 with the Board no later than the agreed commencement date of those services. The insurer, self-insurer, or group self-insurance fund shall also give notice by regular mail or electronic mail of the servicing agent's or third party administrator's name, address and telephone number to the claimants in all existing claims for which it is commencing administration within 14 days of commencing services. When the relationship between the insurer, self-insurer or group self-insurance fund and the servicing agent or third-party administrator is terminated, the insurer, self-insurer, or group self-insurance fund shall file Form WC-121 with the State Board of Workers' Compensation no later than 30 days prior to the date of cessation of services, and shall give notice, by regular mail or electronic mail to all claimants in existing claims which it has been administering.

(e) Within 10 days from the date an employer determines its inability to make payment for workers' compensation benefits, the employer shall notify its surety and the Board in writing of its inability to fulfill its obligations under the Act.

Upon receipt of information establishing an employer's inability to meet its obligations under the Act, or upon notice from an employer that it is unable to meet its obligations under the Act, the Board shall make demand of the surety for payment of the bond or other security held. The Board shall give written notice of the demand for payment to the employer, and all claimants affected by this proceeding.

After the Board receives the proceeds of the bond or other security, then the Board shall determine whether the amount of the security is sufficient to pay all of the employer's obligations arising under this Chapter. If it is not sufficient, the Board shall apportion the proceeds of the bond, or other security held for distribution.

The Board may enter into an agreement with a servicing agent or the Georgia Self-Insurers Guaranty Trust Fund to administer the settlement of claims pursuant to this section.

(f) Rules for third party administrators/servicing agents:

(1) A third-party administrator/servicing agent must be licensed by the Office of Commissioner of Insurance pursuant to O.C.G.A. § 33-23-100 and follow the Rules and Regulations of the Insurance Commissioner's Office Chapter 120-2-49 entitled Administrator Regulations.

(2) The third-party administrator/servicing agent must comply with all sections of O.C.G.A. § 34-9 and all rules and regulations of the Board.

(3) Workers' Compensation claim files of third-party administrators/servicing agents are subject to audit by the Board at any time.

(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.

Rule 126. Proof of Compliance with Insurance Provisions.

(a) 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 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.

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

(2) Termination

(i) Non-renewals

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

(ii) Mid-term cancellation by a licensed insurer

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.

(b) 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 by a group self-insurer fund on Form WC-

11 is evidence that coverage is terminated, effective not less than 15 days after filing.

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

(4) Group self-insurance funds shall file a separate Form WC-11 for each insured member of the fund.

(c) Self-insurers must give written notice to the Board when they add or delete subsidiaries, affiliates, divisions or locations to their self-insurance certificate, or make any changes in their excess insurance policies. (See Rule 382(d).)

Rule 127. Permits for Self-Insurance; Establishment of Offices.

In order for a certificate to be granted by the Board under O.C.G.A. § 34-9-127, the employer desiring to become a self-insurer must designate an office in the State of Georgia for the handling of claims or, if claims are handled out of state, shall designate an agent located in the State of Georgia who shall be authorized to execute instruments for the payment of compensation in an emergency (or, if necessary). 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 through a toll free telephone number. During normal working hours at this office, at least one staff member shall be authorized to execute (negotiable instruments) checks for the payment of compensation. Certificates to self-insure shall be continuous unless the self-insurer fails to meet the requirements of the Board.

Rule 131. Designation by Insurer of Office for Service of Notices.

The most recent address for servicing agents/claims offices submitted by an insurer, self-insured employer, or group self-insurer, on a Form WC-121, Form WC-131, Form WC-131a, or self-insurer's member information annual update shall be used as the address of record for service of forms, notices, orders, and awards.

Rule 200. Compensation for Medical Care; Changes in Treatment; Filing of Medical Reports; Requests for Medical Information.

(a) (1) The employer/insurer have a duty to provide all reasonable and necessary medical treatment in a timely manner and to give appropriate assistance in contacting medical providers when necessary. The employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries.

(2) Payment of compensation for costs by the employer or its insurer directly to the providers of medical, surgical and hospital care and other treatment, items, or services on behalf of the employee or directly to the employee shall satisfy employer's obligation to furnish the employee compensation for costs

of such medical, surgical, hospital care and other treatment, items and services provided for by O.C.G.A. § 34-9-200(a).

(b) (1) Changes in treatment. Except as provided in subsection (b) of O.C.G.A. §34-9-201, changes of physician or treatment are made only by agreement of the parties or by order of the Board. If there has been no hearing requested, a party requesting a change shall make a good faith effort to reach agreement on the change before requesting an order from the Board.

If an agreement cannot be reached, the party requesting the change shall make the request on a Form WC-200b. When filing the WC-200b, the moving party shall sign the Form WC-200b, attach supporting documentation including a separate certificate of service identifying the names and addresses serviced attached to the end of the request, and serve a copy on all counsel and unrepresented parties. In cases that have been designated as "Medical Only", the requesting party shall file a Form WC-14 Notice of Claim or a Form WC-1 along with the Form WC-200b in order for the Board to process the request. The party making the request must specify the reason for the requested change, as well as the date that the change shall be effective. If the argument in support of the request is based on testimony, then an affidavit must be attached to the form, and if the argument refers to documents, then a copy of the documents must be attached. Do not use tabs to separate documents used as evidence. If the Board grants a change, the effective date will be the date that the Form WC-200b was filed, unless otherwise specified.

Any party who objects to the request for a change of physician or treatment shall also file their objection on a Form WC-200b with the Board within 15 days of the date of the certificate of service on the request, including a separate certificate of service identifying the names and addresses served attached to the end of the objection, and serving a copy on all unrepresented parties and counsel. Affidavits and documents must be attached as specified above.

All requests and objections to change of physicians shall be filed on a Form WC-200b and shall be limited to 50 pages, including briefs and exhibits, unless otherwise permitted by an Administrative Law Judge or the Board.

Whenever the pending issues in a request resolve, in part or in whole, the parties or attorneys shall immediately notify the assigned Administrative Law Judge: (1) first, by telephone call; and (2) if so instructed, by subsequent written or electronic confirmation. Any party or attorney who fails to follow this procedure, and who is unable to show good cause for such failure, may be subject to civil penalties and/or assessed attorney's fees.

If a hearing has been requested, the party requesting a change of physician or treatment may include the request in the original request for hearing or amend the hearing request within 15 days prior to the date of the hearing to

include the issue of change of physician or treatment. Upon consideration of the evidence, the Administrative Law Judge will render a decision on all the issues presented.

If the parties agree on a change of physician or treatment, a properly executed Form WC-200a may be filed with the Board, with copies provided to the named medical provider(s) and parties to the claim, which form shall be deemed approved and made the order of the Board pursuant to O.C.G.A. § 34-9-200(b), unless otherwise ordered by the Board.

(2) The party requesting/objecting to a change in physician shall set forth reasons why the change will/will not benefit the employee or provide the employee with medical care reasonably required to effect a cure, give relief, or restore the employee to suitable employment. Factors which may be considered in support of the request/objection may include, but are not limited to, the following:

(i) Proximity of physician's office to employee's residence;
(ii) Accessibility of physician to employee;
(iii) Excessive/redundant performance of medical procedures;
(iv) Necessity for specialized medical care;
(v) Language barrier;
(vi) Referral by authorized physician;
(vii) Noncompliance of physician with Board Rules and procedures;
(viii) Panel of physicians;
(ix) Duration of treatment without appreciable improvement;
(x) Number of prior treating physicians;
(xi) Prior requests for change of physician/treatment;
(xii) Employee released to normal duty work by current authorized treating physician;
(xiii) Current physician indicates nothing more to offer.

(3) When filing a motion for reconsideration, the parties or attorneys shall: (1) immediately notify the Board or assigned Administrative Law Judge by telephone call; (2) use the ICMS doc-type labeled motion for reconsideration; (3) limit their motion to 20 pages, including briefs and exhibits, unless otherwise permitted by the Board or an Administrative Law Judge; and (4) serve a copy on all counsel and unrepresented parties, along with supporting documents, including a separate certificate of service identifying the names and addresses served.

(c) (1) As long as an employee is receiving compensation, he or she shall submit himself or herself to examination by the authorized treating physician scheduled by the employer/insurer at reasonable times and with reasonable notice. If the employee refuses to submit himself or herself to or in any way obstructs such an examination requested by and provided for by the employer, upon order of the board his or her right to compensation shall be suspended until such refusal or objection ceases and no compensation shall at any time be payable for the period of suspension unless in the opinion of

the board the circumstances justify the refusal or obstruction.

(2) Nothing contained herein shall be construed to abridge the employee's continued right to schedule his/her appointments for authorized medical treatment.

(d) The employer/insurer may suspend weekly benefits for refusal of the employee to submit to examinations only by order of the Board.

(e) Medical Reports.

The employer/insurer shall not file with the Board a medical report for any injury which occurred after January 1, 1989, except as follows:

(1) The report or its attachments contains a permanent partial disability rating (file within 10 days of employer/insurer's receipt);

(2) A rehabilitation plan is filed with the Board. In such instance the medical reports shall be filed with the rehabilitation plan;

(3) Medical reports are requested by the Board (file within 10 days of request.)

Any additional medical reports required shall be filed within 10 days of the employer/insurer's receipt of same. The employer/insurer shall maintain copies of all medical reports in their files and shall not file medical reports except in compliance with this Rule.

(f) (1) Requests for Medical Information. The employee shall, upon the request of the employer/insurer, furnish copies of all medical records and reports which are in his/her possession concerning the treatment for the accident which is the subject of the claim. The employee shall furnish the copies within 30 days of the date of the request. The employer/insurer shall pay the reasonable cost of the copies as provided by the Board-approved fee schedule.

(2)The employer /insurer shall, upon the request of the employee, furnish a copy of the posted panel of physicians, and copies of all medical records and reports in their possession, concerning the treatment for the accident which is the subject of the claim, and shall, upon request of the employee, furnish copies of all medical records and reports which were obtained with a release of the employee provided pursuant to O.C.G.A. § 34-9-207(b), within 30 days of the date of the request at no expense to the employee.

(3) 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 concerning the treatment for the accident which is the subject of the claim, at no expense to the employee or his/her attorney. A reasonable cost for copies pursuant to the fee schedule may be charged against the party determined to be responsible for payment of medical expenses. Nothing in this Rule shall limit an employee's right to obtain a complete copy of his/her medical records from any health care provider.

(g) Physicians as defined in O.C.G.A. §34-9-201(a) may be called upon and may be issued a subpoena requiring their testimony as expert witnesses based upon their examinations and treatment of employees alleging work-related injuries. In lieu of live testimony at hearings in cases pending before the State Board of

Workers' Compensation regarding matters subject to the Act, as permitted under O.C.G.A. §24-10-24 (24-13-24 effective 1/1/13), depositions may be taken pursuant to O.C.G.A. §34-9-26 *et seq* and *O.C.G.A. §34-9-102(d)(3)*, and said physicians shall be compensated for their preparation time and actual time pursuant to the provisions of the Board approved Fee Schedule or by a fee agreement agreed to by the parties and the physician.

Rule 200.1. Provision of Rehabilitation Services.

(I) REHABILITATION SUPPLIERS

A rehabilitation supplier delivers and coordinates services under an individualized rehabilitation plan; facilitates coordination of medical care; provides vocational counseling, exploration, and assessment; performs job analysis, job development, modification, and placement; evaluates social, medical, vocational, psychological, and psychiatric information; and may provide additional services upon agreement of the parties or Board order.

(A) Qualified Certifications or Licenses

To provide rehabilitation services, the supplier must be registered with the Board. To provide services in catastrophic claims, the supplier must be registered with the Board as a catastrophic supplier.

Any rehabilitation supplier who wishes to supply services in a Workers' Compensation claim shall hold one of the following certifications or licenses:

(1) Certified Rehabilitation Counselor (CRC);
(2) Certified Disability Management Specialist (CDMS);
(3) Certified Rehabilitation Registered Nurse (CRRN);
(4) Work Adjustment and Vocational Evaluation Specialist (WAVES);
(5) Licensed Professional Counselor (LPC);
(6) Certified Case Manager (CCM);
(7) Certified Occupational Health Nurse (COHN); or
(8) Certified Occupational Health Nurse Specialist (COHN-S).

(B) Registration with the Board

(1) To register as a rehabilitation supplier or a catastrophic rehabilitation supplier, an applicant shall follow the application process as provided in the Board's Rehabilitation & Managed Care Procedure Manual.

(2) Notice of a rehabilitation supplier's registration approval will contain a supplier registration number with the November 30th expiration date, which shall be included on all reports submitted to the Board by the rehabilitation supplier.

(3) Within twenty (20) days of the date of a denial of an application for registration as a supplier, an appeal may be initiated by filing a written request with the Director of Managed Care and Rehabilitation (MC&R) for a conference. The applicant will be notified in writing of the date, time, and place of the conference within thirty days of the appeal. An applicant dissatisfied with the decision following the conference may request a hearing by written request within twenty (20) days of the conference decision.

(II) CATASTROPHIC REHABILITATION SERVICES

(A) **Appointment of Catastrophic Rehabilitation Supplier**

(1) Where catastrophic designation is undisputed, the employer/insurer shall appoint a registered catastrophic rehabilitation supplier within 48 hours of accepting the injury as compensable or notification of a final determination of compensability by filing a Form WC-R1which may be filed simultaneously with the Employer's First Report of Injury (WC-1). If the employer/insurer does not timely appoint a registered catastrophic rehabilitation supplier as required pursuant to this subsection, the employee may file a WC-R1 to request the appointment of a registered catastrophic rehabilitation supplier with service to all parties and the requested supplier.

(2) When a catastrophic designation is disputed, employee or employee's attorney shall file a WC-R1CATEE to request catastrophic designation and appointment of a registered catastrophic rehabilitation supplier. The WC-R1CATEE must be accompanied by documentation as specified in the current edition of the Board's Rehabilitation & Managed Care Procedure Manual, or as requested by the Board, unless a hearing is requested within twenty (20) days of the filing of the WC-R1CATEE.

(3) Objection to the WC-R1CATEE must be filed on a Form WC-Rehab Objection with the Board within twenty (20) days of the certificate of service on the WC-R1CATEE. In the alternative, either party may file a Form WC-14 requesting an evidentiary hearing within twenty (20) days of the certificate of service on the WC-RICATEE. In the event a Form WC-14 is filed, the file shall be transferred to an administrative law judge for an evidentiary hearing without an administrative decision being rendered by the Rehabilitation Coordinator. The timeliness of the objection or hearing request will be processed in accordance with provisions of O.C.G.A. §9-ll-6(e).

(4) When a Board determination is made by the MC & R or an administrative law judge that an injury is catastrophic, the employer/insurer shall have twenty (20) days from the date of notification of the determination to select a Board registered catastrophic rehabilitation supplier by filing a WC-R1. If the employer/insurer fails to select a supplier, or files an appeal

of the determination to the Appellate Division and the catastrophic designation is upheld on appeal, the Board will select the catastrophic rehabilitation supplier, and may, in the Board's discretion, appoint a supplier requested by the employee.

(**B) Catastrophic Rehabilitation Supplier Duties**

(1) A catastrophic rehabilitation supplier is not a party to the case. The registered catastrophic rehabilitation supplier shall have sole responsibility for the rehabilitation aspects of each individual case. The registered catastrophic rehabilitation supplier shall communicate with the injured employee and others to assess, plan, implement, coordinate, monitor and evaluate options and services to meet an injured employee's rehabilitation needs to effect a cure, give relief or restore the employee to suitable employment.

(2) The registered catastrophic rehabilitation supplier shall meet with the injured employee within thirty (30) days of appointment and complete an initial rehabilitation evaluation and an appropriate plan (WC-R2A) for medical and/or vocational services.

(3) The designated rehabilitation supplier may arrange for services outside of his/her scope of expertise and qualifications.

(4) Form WC-R2 with accompanying progress/status reports shall be filed no less than every ninety days.

(5) A rehabilitation supplier will inform all parties of the responsibility to provide services in accordance with their professional qualifications. The rehabilitation supplier shall function within the scope of his or her role, training, and technical competency and will accept only those referrals and/or assignments for which he or she is professionally qualified.

(6) The rehabilitation supplier shall disclose any known conflicts of interest.

(7) The rehabilitation supplier shall recognize that the authorized treating physician directs the medical care of an injured employee.

(8) The rehabilitation supplier shall insure the confidentiality of the injured employee's medical records and shall not disclose the medical records to non-parties without the written consent of the injured employee or unless otherwise legally required to do so.

(9) A rehabilitation supplier shall refrain from activity pertaining to settlement negotiations, surveillance or provision of legal advice.

(10) Rehabilitation suppliers shall advise a non-represented injured employee to direct questions outside his/her area of expertise to the State Board of Workers' Compensation and a represented injured employee to direct questions to his or her counsel.

(11) A rehabilitation supplier shall not accept any additional compensation or reward from any source as a result of settlement of a case.

(12) The assigned rehabilitation supplier shall not perform any additional services for either party for compensation not contemplated by the approved plan unless all parties agree.

(**C) Rehabilitation Plans**

(1) The initial rehabilitation plan must be filed with the Board on Form WC-R2A within ninety (90) days of the supplier's appointment to the claim, unless excused by the Board. A current Rehabilitation Plan must be filed with the Board during all phases of service delivery and shall be in place no longer than one year. All rehabilitation plans shall provide for reasonable and necessary items and services and be submitted with supporting documentation. If the Board rejects the proposed rehabilitation plan, the registered catastrophic rehabilitation supplier shall have 30 days to submit a revised plan. An amended rehabilitation plan on a WC-R2A shall be filed at any time the circumstances change significantly. Amended or extended rehabilitation plans shall be submitted thirty days prior to the expiration of the current approved plan.

(2) Plans may include any or all of the items and services, including housing and transportation, which are reasonable and necessary to return the catastrophically injured employee to the least restrictive lifestyle possible, and/or return to work including: Medical Care Coordination, Independent Living, Extended Evaluation, Job Placement, Training and /or Self Employment.

(3) Return-to work plans, in order of preference, are: a) return to same job with the same employer; b) return to different job with same employer; c) return to work with new employer; d) short-term training; e) long-term training; or f) self-employment.

(4) Any party objecting to a proposed rehabilitation plan shall file a WC-Rehab Objection Form with the Board within twenty (20) days of the date of the certificate of service. The Rehabilitation Division will issue an administrative decision and may hold a rehabilitation conference.

(5) Signed plans submitted without objection are approved automatically.

(D) Communication

(1) A catastrophic rehabilitation supplier shall simultaneously provide copies of all correspondence, written communication, and documentation of oral communications with the treating physician to all parties and their attorneys.

(2) The catastrophic rehabilitation supplier shall provide professional identification and shall explain his or her role to any physician at the initial contact with the physician.

(3) The employee has the right to a private physical examination with the medical provider. The catastrophic rehabilitation supplier shall attend such examination, only with revocable written consent of the employee, or his or her representative, after the employee has been advised of the right to a private examination. The catastrophic rehabilitation supplier may meet with the physician and the employee after the private exam.

(4) The catastrophic rehabilitation supplier shall not obtain medical information regarding an injured employee in a private meeting with any treating physician unless the catastrophic rehabilitation supplier has reserved with the physician sufficient appointment time for the conference and the injured employee and his or her attorney were given ten days advance notice of their option to attend the conference. If the injured employee or the physician does not consent to a joint conference, or if, in the physician's opinion, it is medically contraindicated for the injured employee to participate in the conference, the catastrophic rehabilitation supplier shall note this in his or her report and may in those specific instances communicate directly with the physician. Exceptions to the above notice requirements may be made in cases of medical necessity or with the consent of the injured employee or his or her attorney.

(**E**) **Rehabilitation Conferences**

(1) A rehabilitation conference may be scheduled at the request of a party or the catastrophic rehabilitation supplier by filing a WC-R5, or at the discretion of an Administrative Law Judge or the Board's rehabilitation coordinator.

(2) All parties, attorneys of record, and the catastrophic rehabilitation supplier may be required to attend the conference or to be represented by a person with full authority to resolve the pending disputes. Only the parties, attorneys of record, and catastrophic rehabilitation supplier may attend a scheduled mediation or rehabilitation conference. Exceptions to attendance may be granted if approved in advance by the Board rehabilitation coordinator.

(3) Any person notified by the Board who fails to attend a Board scheduled rehabilitation conference without reasonable grounds may be subject to sanction pursuant to O.C.G.A. § 34-9-18. Any party requesting cancellation or rescheduling of a rehabilitation conference shall notify the Board and other parties with adequate notice to all parties.

(4) Following the rehabilitation conference, the Board will issue a conference administrative decision.

(F) Rehabilitation Closure

(1) The registered catastrophic rehabilitation supplier shall submit a WC-R3, Request for Closure, with a closure report as follows: (a) sixty days after the employee's return to work; (b) at any time it is determined that further services are not needed or feasible; (c) when a stipulated settlement that does not include rehabilitation services has been approved by the Board; or (d) when the Board directs rehabilitation closure.

(2) At any time, upon review of the file, the Board may determine that rehabilitation closure is appropriate and may issue an order or an administrative decision to close rehabilitation.

(3) A party may request that the Board close rehabilitation services by filing a WC-R3 setting forth the specific reasons in support of their request for closure with copies to all parties and the supplier.

(4) Any party objecting to a proposed WC-R3 shall file a WC-Rehab Objection Form setting forth the specific reasons within twenty (20) days of the date of the certificate of service. The Board will issue an administrative decision on all requests for closure.

(G) Request to Reopen Rehabilitation

(1) A request to reopen rehabilitation services may be submitted only by parties to the claim and must be approved by the Board. The WC-R1 requesting that rehabilitation services be reopened shall include the name and address of the catastrophic rehabilitation supplier and the specific reasons for such request. The requesting party shall complete the certificate of service and send copies of the WC-R1 to all parties, their attorneys and the catastrophic rehabilitation supplier.

(2) Any party objecting to a proposed reopening shall file a WC-Rehab Objection Form with supporting documentation within twenty days of the date of the certificate of service. The M C & R will issue an administrative decision on all requests to reopen rehabilitation.

(H) Change in Registered Catastrophic Rehabilitation Supplier

(1) A change in registered catastrophic rehabilitation supplier shall be requested only by parties to the claim and must be approved by the Board. The WC-R1 requesting a change in supplier shall include the names and addresses of the involved suppliers and the specific reasons the change is requested. The requesting party shall complete the certificate of service and send copies of the WC-R1 to all parties, their attorneys and the catastrophic rehabilitation suppliers.

(2) When a WC-R1 is filed to request a change of registered catastrophic rehabilitation supplier, the current Board appointed rehabilitation supplier shall maintain responsibility for providing necessary rehabilitation services until all appeals have been exhausted, unless excused by the Board.

(3) Any party objecting to a change of catastrophic rehabilitation supplier shall file a WC-Rehab Objection Form setting forth the reasons in support within **fifteen (15)** days of the date of the certificate of service. The Rehabilitation Division may hold a rehabilitation conference. The Rehabilitation Division will issue an administrative decision on all change of supplier requests.

(I) Challenges to Administrative Decisions

Any party to the claim dissatisfied with an administrative decision must file a WC-14, Request for Hearing, served on all parties and their attorneys and involved rehabilitation supplier(s) within twenty (20) days of the date of the administrative decision. The Board, in its discretion, may order the parties to participate in a mediation or rehabilitation conference before the scheduling of the de novo hearing. The administrative decision shall be admissible in evidence.

(J) Failure of a Party or Counsel to Cooperate

(1) Benefits may be suspended for failure or refusal to accept or cooperate with authorized rehabilitation services only by order of the Board.

(2) A party or attorney may be subject to civil penalty or to fee suspension or reduction for failure to cooperate with rehabilitation services.

(III) VOLUNTARY REHABILITATION

For non-catastrophic injuries, the parties may elect that the employer/insurer will provide a rehabilitation supplier on a voluntary basis for so long as the parties agree. The employee's consent must be in writing. The rehabilitation supplier utilized by the parties must hold one of the certifications or licenses specified in Rule 200.1(I.A.) and be registered with the State Board of Workers' Compensation.

(A) Duties of voluntary rehabilitation supplier

The voluntary rehabilitation supplier shall simultaneously provide copies of all correspondence, written communications, and documentation of oral communications with the treating physician to all parties and their attorneys.

(B) Ethical standards required of voluntary rehabilitation supplier

The rehabilitation supplier shall adhere to the ethical standards set forth by the approved professional certifying bodies.

(IV) ADMINISTRATIVE ENFORCEMENT- PROFESSIONAL CONDUCT, FEES AND COMPLIANCE WITH BOARD RULES

Complaints against rehabilitation suppliers and medical case managers for revocation or suspension of registration, excessive or fraudulent charges, provision of unnecessary services or unethical or unprofessional behavior shall be filed in writing on a Rehab Complaint with the Director of Managed Care and Rehabilitation with copies sent to all parties and affected suppliers and case managers. Registration may be revoked or suspended, and/or penalties assessed.

(A) The Director of MC&R shall appoint a peer review panel of nine (9) registered suppliers who will review complaints regarding reasonable fees, appropriate services and unprofessional or unethical behaviors. The appointees shall serve for terms of three (3) years and may be re-appointed for a maximum of nine (9) years.

(B) The registration of a medical case manager or a rehabilitation supplier may be revoked or suspended, and/or penalties assessed upon a determination of violation of Board rules, excessive or fraudulent charges, provision of unnecessary services or unethical or unprofessional behavior.

(C) A written complaint against a medical case manager or rehabilitation supplier shall be filed with the Director of MC&R and copies sent to all parties to the case and to the medical case manager or rehabilitation supplier. Upon receipt of the written complaint, or upon the Board's knowledge of a violation, the Director of MC& R shall provide notification to the case manager/rehabilitation supplier by providing a copy of the written complaint.

(D) Within fifteen (15) calendar days of the notice by the Director of MC&R, the Director shall appoint a panel of three (3) members from the peer review panel to review the complaint. Where possible, at least one of the three (3) shall have the same certification or licensure as the person who is the subject of the complaint. The Director of MC&R shall provide Review Panel contact information to the complainant and the person who is the subject of the complaint.

(E) The medical case manager or rehabilitation supplier who is the subject of the complaint shall be provided fifteen (15) calendar days from the date of said notice from the Director to provide a written response to the allegations of the complaint. A copy of the response shall be served on the Director of MC&R, the Review Panel, and the person who filed the complaint.

(F) The complainant may reply to the response within 10 days by serving a copy on the Director of MC&R, the person who is the subject of the complaint, and the Review Panel.

(G) The Review Panel may request additional information regarding the circumstances of the complaint from any person or party having relevant

knowledge. Such additional information shall be provided to the person who is the subject of the complaint who will have 10 days to respond

(H) The Review Panel shall report its findings and recommendations to the Director of MC&R within thirty (30) days of the final response. The Director of MC&R shall promptly provide a copy of the findings and recommendations to the medical case manager or rehabilitation supplier who is the subject of the complaint and the complainant.

(I) If the Review Panel determines that there is no inappropriate conduct, the Director of MC&R shall issue an administrative decision incorporating the Review Panel's findings and recommendation. Copies of the finding shall be sent to all parties to the case and to the medical case manager or rehabilitation supplier who was the subject of the complaint. The complainant or any party dissatisfied with the finding may challenge the finding by filing a WC-14 Request for Hearing within 20 days. The administrative decision shall be admissible in evidence.

(J) If the Review Panel determines that a violation has occurred, the Director of MC&R will refer the findings and recommendation to the Enforcement Division for further appropriate action which may include referral to an Administrative Law Judge for a hearing. If a hearing is held, the Administrative Law Judge shall issue a decision providing for any available remedy, including dismissal of the complaint, assessment of penalties, probation, and/or revocation or suspension of the registration of the rehabilitation supplier. The rehabilitation supplier may appeal the decision of the Administrative Law Judge in accordance with O.C.G.A. § 34-9-103 and § 34-9-105.

(K) The Director of MC&R shall also have the authority to order replacement of the rehabilitation supplier in the case where the conduct occurred if, in the judgment of the Director of MC&R, such action is necessary to effectuate the purpose of the Act.

(L) When appeals have been exhausted, the Director of MC&R shall report any violations to the appropriate certification or licensing Board.

(M) The members of the peer review panel shall be immune from any subpoena requiring their testimony in any form regarding their participation in the review process.

Rule 200.2. Medical Case Management

(A) **Qualified Medical Case Managers**. In claims involving non-catastrophic injuries, employers/insurers may voluntarily utilize qualified medical case managers to provide telephonic or field medical case management services. Such medical

case management services may be provided at the expense of the employer/insurer.

(1) **Certifications or Licenses**. Qualified medical case managers must possess one or more of the following certifications or licenses:

(a) Certified Rehabilitation Counselor (CRC);
(b) Certified Disability Management Specialist (CDMS);
(c) Certified Rehabilitation Registered Nurse (CRRN);
(d) Work Adjustment and Vocational Evaluation Specialist (WAVES);
(e) Licensed Professional Counselor (LPC);
(f) Certified Case Manager (CCM);
(g) Certified Occupational Health Nurse (COHN); or
(h) Certified Occupational Health Nurse Specialist (COHN-S).

(2) **Registration**. Qualified medical case managers must be registered with the Board as provided in the Board's Rehabilitation and Managed Care Procedure Manual.

(B) **Consent of Employees and Qualified Medical Case Manager Duties**.

(1) Consent of the employee or the employee's attorney shall be required for any qualified medical case manager to work with the injured worker. Consent shall be in writing when attending any medical appointment.

(2) Consent of the employee shall not be required for qualified medical case managers to contact the treating physician for purposes of assessing, planning, implementing, and evaluating the options and services required to effect a cure or provide relief.

Prior to initially contacting an employee's treating physician, a qualified medical case manager working without the consent of the employee must give all parties and attorneys of record written notification of being retained by the employer/insurer.

(3) Where consent is required, it may be withdrawn and the employee shall be informed in writing that such consent may be refused.

(4) Nothing in this rule shall be construed to allow or promote utilization review on the part of the qualified medical case manager.

(5) The qualified medical case manager may assist with approval of job descriptions only as consistent with O.C.G.A. § 34-9-240 and Board Rule 240.

(C) **Communication**.

(1) All communications are subject to the provisions of Rule 200.1(II)(D).

(2) The qualified medical case manager shall provide copies of all medical records, medical reports, office notes, test results, and all other written documents received from the employee's treating physician to all parties and their attorneys.

(D) **Administrative Enforcement – Professional Conduct, Fees, and Compliance with Board Rules**. Violations of this rule may be referred to the Managed Care and Rehabilitation Division for peer review as contemplated by Board Rule 200.1(IV).

(E) **Qualified Medical Case Management Involvement with Managed Health Care Providers**. Qualified medical case managers may be involved in cases where the employer/insurer has contracted with a certified workers' compensation managed care organization (WC-MCO). In such claims, qualified medical case

managers shall operate pursuant to the provisions of O.C.G.A. § 34-9-208 and Board Rule 208.

(F) **Attorneys and Direct Employees**. Nothing contained in this Rule shall apply to a direct employee of the insurer, third party administrator, or employer, or to an attorney representing a party, provided that their specific role is identified.

Rule 201. Panel of Physicians.

(a) The employer may satisfy the requirements for furnishing medical care under O.C.G.A. § 34-9-200 in one of the following manners:

(1)(i) A traditional posted panel of physicians shall consist of at least six physicians or profession associations or corporations of physicians who are reasonably accessible to the employees but is not limited to the minimum of six. However, should a physician on the panel of physicians refuse to provide treatment to an employee who previously has received treatment from an associated panel physician, the employer/insurer, as soon as practicable, shall increase the panel for that employee 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 four physicians or groups of physicians are not reasonably accessible. The physicians selected under this subsection from the panel may arrange for any consultation, referral, and extraordinary or other specialized medical services as the nature of the injury shall require without prior authorization from the Board; provided, however, that any medical practitioner providing services as arranged by a primary authorized treating physician under O.C.G.A. § 34-9-201(b)(1) shall not be permitted to arrange for any additional referrals. The minimum panel shall include an orthopedic physician, and no more than two physicians shall be from industrial clinics. Further, this panel shall include one minority physician. The minority physician so selected must practice within the State of Georgia or be reasonably accessible to the employee's residence. “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. Failure to include one minority physician on the panel does not necessarily render the panel invalid. The Board reserves the right to allow exceptions when warranted. The employee may make one change from one physician to another on the same panel without prior authorization of the Board. The party which challenges the validity of a panel shall have the burden of proving that the panel violates the provisions of O.C.G.A. § 34-9-201 and Board Rule 201.

(ii) In the event that the Board has granted any exceptions to the panel requirements, all exceptions must be posted at the same location as the panel.

(iii) In addition to posting of the panel of physicians upon the business premises, “posting” of the Panel of Physicians (WC-P1) pursuant to O.C.G.A. §34-9-201(c) and the Bill of Rights (WC-BOR) pursuant to Rule 81.1 may include electronic publication of the information via on-line access. When posting via electronic publication, the employer shall provide a website or free application with access instructions to the employee. In the event the employee has no internet access,

the employer shall provide the employee with access to the panel. On-line posting shall not eliminate the requirement of posting the panel of physicians on the business premises of the employer.

(2) An employer or the workers' compensation insurer of an employer may contract with a workers' compensation managed care organization certified pursuant to O.C.G.A. § 34-9-208 and Board Rule 208. A “workers' compensation managed care organization” (hereinafter “WC/MCO”) means a plan certified by the Board that provides for the delivery and management of treatment to injured employees under the Georgia Workers' Compensation Act. The party which challenges the validity of the WC/MCO panel shall have the burden of proving that the panel violates the provisions herein. An employer utilizing a WC/MCO may satisfy the notice requirements of O.C.G.A. § 34-9-201(c) by posting a notice in prominent places upon the business premises which includes the following information:

(A) The employer has enrolled with the specified WC/MCO to provide all necessary medical treatment for workers' compensation injuries. An employee with an injury prior to enrollment may continue to receive treatment from the non-participating authorized treating physician until the employee elects to utilize the WC/MCO;

(B) The effective date of the WC/MCO;

(C) The geographical service area (by counties);

(D) The telephone number and address of the administrator for the employer and/or WC/MCO who can answer questions about the managed care plan;

(E) How the employee can access care with the WC/MCO and the toll-free 24-hour telephone number of the managed care plan that informs employees of available services.

(b) The employer/insurer cannot restrict treatment of the employee to the panel of physicians or WC/MCO when the claim has been controverted. 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 after notice has been given to the employer, that physician so selected 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) When a case has not been controverted but the employer fails to provide any of the procedures for selection of physicians as set forth in O.C.G.A. § 34-9-201(c), the employee is authorized to select a physician who is not listed on the employer's posted panel of physicians or WC/MCO. After notice has been given to the employer, that physician so selected becomes the authorized treating physician, and the employee may 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.

(d) A party requesting a change of physician must do so in the manner prescribed by Board Rule 200.

Rule 202. Examinations.

(a) Examinations contemplated by O.C.G.A. § 34-9-202 shall include physical, psychiatric and psychological examinations. An examination shall also include reasonable and necessary testing as ordered by the examining physician.

(b) The examining physician may require prepayment pursuant to the Fee Schedule base amount for up to the first two hours ($1200.00). Payment for any additional charges pursuant to the Fee Schedule shall be due within 30 days of receipt of the report and charges by the employer/insurer.
(c) The employer shall give ten days written notice of the time and place of any requested examination. Advance payment of travel expenses required by Rule 203(e) shall accompany such notice.
(d) The employer/insurer shall not suspend weekly benefits for refusal of the employee to submit to examination except by order of the Board.
(e) Within 120 days of the employee's receipt of any income benefits, the employee shall provide written notice to the employer/insurer of his/her intent to exercise the right to have a one-time independent medical examination at a reasonable time and place.

Rule 203. Payment of Medical Expenses; Procedure When Amount of Expenses are Disputed.

(a) Medical expenses shall be limited to the usual, customary and reasonable charges as found by the Board pursuant to O.C.G.A. § 34-9-205. Employer/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 charges. Requests for reimbursement of mileage expenses incurred by the employee shall be paid within 15 days after receipt of an itemized written request. Employer/insurers shall not unilaterally change any CPT-4 or CDT code of the provider. All automatically conformed charges 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 carrier, self-insured employer, 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. In all claims, any health service provider whose fee is reduced to conform to the fee schedule and who disputes that fee, or employer/ insurers who dispute the CPT-4 or CDT code used by the provider for services rendered shall, in the first instance, request peer review of the charges, and may thereafter request a mediation conference or an evidentiary hearing by filing Form WC-14 with the Board. For disputed charges or payments, the aggrieved party shall

follow the procedures provided in subsections (b) and (c).

(b) (1) A medical provider or an employee who has incurred expenses for healthcare goods and services or other medical expenses shall submit the charges to the employer or its workers' compensation carrier for payment within one year of the date of service. In the event that the claim or the expense is controverted, the medical expenses or request for reimbursement must be submitted for payment within one year of the date of service or within one year of the date that the claim is accepted or established as compensable, whichever is later. Failure by the medical provider or employee to submit expenses within the time prescribed shall result in waiver of such expenses.

(2) Any challenge by a medical provider to the amount of payment for goods, services, or expenses shall be submitted to the payer within 120 days of payment. Failure by a medical provider to challenge the amount of payment of such goods, services, or expenses within 120 days shall result in the waiver of additional payment. If the challenge is not resolved, the medical provider may request peer review as provided in subsection (c).

(c) Disputes

(1) An employer or insurer shall pay when due all charges deemed reasonable, and follow the procedures set forth in subsection (2) for review of only those specified charges which are disputed.

(2) For charges not contained in the fee schedule, or allegedly not paid pursuant to the fee schedule, and/or which are otherwise disputed as not being the usual, customary and reasonable charges prevailing in the State of Georgia, the employer, insurer, or physician shall file a request for peer review with a peer review organization authorized by the Board within 180 days of the payment, reduction denial, or decision of an appeal of charges by the employer/insurer, and shall serve a copy of the request and supporting documentation upon all parties and counsel, and shall follow the rules of the peer review organization with respect to any required additional copies.

The peer review organizations approved by the Board are listed on the Board's website at www.sbwc.georgia.

(3) Unless peer review is requested as set forth in Rule 203(c)(2), all reasonable charges for medical, surgical, hospital and pharmacy goods and services shall be payable by the employer or its worker's compensation insurer within 30 days from the date that the employer or the insurer receives the charges and the medical reports required by the Board or within 15 days after receipt of an itemized written request for mileage incurred by the employee. Failure of the health care provider to include with submission of charges the reports or other documents required by the Board, constitutes a defense for the employer or insurer's failure to pay the submitted charges within 30 days of receipt, or within 15 days of receipt of an itemized written request for mileage incurred by the employee; however, the employer or

insurer must submit to the health care provider or employee written notice indicating the need for further documentation within 30 days of receipt of the charges or within 15 days of an itemized written request for mileage incurred by the employee and failure to do so will be deemed a waiver of the right to defend a claim for failure to pay such charges in a timely fashion on the ground that the charges were not properly accompanied by required documentation. Such waiver shall not extend to any other defense the employer and insurer may have with respect to a claim of untimely payment.

If any charges for health care goods or services are not paid when due, or any reimbursement for health care goods or services paid by the employee or any charges for mileage incurred by the employee are not paid when due, penalties shall be added to such charges and paid at the same time as, and in addition to, the charges claimed for the health care goods and services. For any payment of charges made more than 30 days after their due date, but paid within 60 days of such date, there shall be added to such charges an amount equal to 10 percent of the amount due. For any payment of charges made more than 60 days after the due date, but paid within 90 days of such date, there shall be added to such charges an amount equal to 20 percent of the amount due. For any charges not paid within 90 days of the due date, in addition to the 20 percent add-on penalty, the employer or insurer shall pay interest on the combined total in an amount equal to 12 percent per annum from the 91st day after the date the charges were due until full payment is made. All such penalties and interest shall be paid to the provider of the health care goods or services.

(4) No penalties or interest shall be due on disputed charges submitted to peer review until the peer review organization makes a decision regarding the disputed charges.

(5) The employer, insurer, or physician requesting review must comply with the requirements of the statute, Board Rules, and rules of the appropriate peer review organization before the Board will rule on any disputed charges.

(6) If there is no appropriate peer review organization, the party requesting review may request a mediation conference by filing Form WC-14 with the Board. The charges submitted which conform to the list as published by the Board shall be prima facie proof of the usual, customary, and reasonable charges for the medical services provided.

(7) The employer/insurer shall, within 30 days from the date that a decision regarding the peer review of charges or treatment is issued by a peer review organization, make payment of disputed charges based upon the recommendations, or request a mediation conference or an evidentiary hearing. The peer review organization shall serve a copy of its decision upon the employee if unrepresented, or the employee's attorney. A physician whose fee has been reduced by the peer review organization shall have 30 days from the date that the recommendation is mailed to request a mediation or hearing. In the event of a hearing or mediation conference, the recommendations of the peer review organization shall be evidence of the

usual, customary, and reasonable charges.

(8) The penalties and interest for late payment detailed in Paragraph (c)(3) above shall not be applicable until after a decision by a peer review organization or a final decision of the Board after a hearing, whichever is later.

(9) In the event the decision of the peer review organization is that the fee be reduced, the employer/insurer shall pay the physician the fee amount recommended by the peer review organization less the fee for peer review initially paid by the employer/insurer. In the event the decision of the peer review organization is that the entire fee be disallowed, the employer/insurer may automatically deduct the fee for the peer review from future allowable expenses submitted by the physician for treatment or services rendered to the employee arising out of the same injury.

In the event the decision of the peer review organization is that an additional fee is due the medical provider, the employer/insurer shall pay the medical provider the additional fee plus the fee for peer review initially paid by the medical provider.

(10) Peer review shall not apply to charges not yet incurred for prospective medical treatment, services, or equipment.

(11) Peer review shall not apply or be utilized to determine the issue of necessity of treatment or services.

(d) Medical expenses shall include the reasonable cost of attendant care that is directed by the treating physician, during travel or convalescence.

(e) 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 or physical therapy, or the pharmacy. When travel is by private vehicle the rate of mileage shall be 45 cents per mile. This rate is subject to change based upon changes in fuel costs. Reimbursement for any charges for mileage incurred by the employee shall be paid within 15 days from the date that the employer or the insurer receives the itemized written request required by the Board. Travel expenses beyond the employee's home city shall include the actual cost of meals and lodging. Travel expenses shall further include the actual cost of meals when total elapsed time of the trip to obtain outpatient treatment exceeds four hours. Cost of meals shall not exceed $30 per day.

Rule 204. Subsequent Non-Work Related Injury; Chain of Causation; Burden of Proof.

The employer/insurer shall not suspend weekly benefits on the ground that a subsequent nonwork related injury has broken the chain of causation between the compensable injury and the employee's disability except by the order of the Board. The burden of proving that the chain of causation has been broken shall be upon the employer/insurer.

Rule 205. Necessity of Treatment; Disputes Regarding Authorized Treatment; Failure to Attend Medical Appointment.

(a) Reports required by the Board include State Board of Workers' Compensation Form WC-20(a), 1500 Claim Form, UB-04 or American Dental Association Form 2012 and supporting narrative, if any, properly filled out and with supporting itemized hospital charges, discharge summary, and billings from other authorized providers of service and shall be furnished at no charge to the party responsible for payment. In addition, health care providers may submit and payers may receive and pay bills for medical services and products provided to the injured employee electronically in accordance with the Medical Billing and Reimbursement for Workers' Compensation procedures outlined in an Appendix to the Georgia Fee Schedule. Medical services provided pursuant to the Workers' Compensation Act are not confidential to the employer/insurer who by law are responsible for the payment of services. Hospitals and other medical providers who by their own rules require medical releases shall be responsible for obtaining same at the time of treatment.

(b) (1) Medical treatment/tests prescribed by an authorized treating physician shall be paid, in accordance with the Act, where the treatment/tests are:

(a) Related to the on the job injury;

(b) Reasonably required and appear likely to accomplish any of the following:

(1) Effect a cure;

(2) Give relief;

(3) Restore the employee to suitable employment;

(4) Establish whether or not the medical condition of the employee is causally related to the compensable accident.

(2) Advance authorization for the medical treatment or testing of an injured employee is not required by this Chapter as a condition for payment of services rendered. A Board-certified WC/MCO may provide for pre-certification by contract with network providers pursuant to O.C.G.A. § 34-9-201(b)(3).

(3) (a) An authorized medical provider may request advance authorization for treatment or testing by completing Sections 1 and 2 of Board Form WC-205 and faxing or emailing same to the insurer/self-insurer, along with supporting medical documentation. The insurer/self-insurer shall respond by completing Section 3 of the WC-205 within five (5) business days of receipt of this form. The insurer/self-insurer's response shall be by facsimile transmission or email to the requesting authorized medical provider. If the insurer/self-insurer fails to respond to the WC-205 request within the five-business day period, the treatment or testing stands pre-approved.

(b) 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 the 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 controversion.

(4) Where the employer fails to comply with Rule 205(b)(3), the employer shall pay for the treatment/test requested related to the compensable injury in accordance with the Chapter.

(c) Except as provided in Rule 205(e);

(1) When an authorized treating provider has recommended medical treatment/testing, which includes all items and services as defined by OCGA §34-9-200, 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 to show cause why the medical treatment/testing that has been recommended should not be authorized. (Section B of WC-PMT). 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.

(2) When an appointment has been scheduled for the Employee with an authorized treating physician and Employee has been provided with at least 5 business days advance notice of such appointment but failed to attend, the Employer/Insurer may file a petition to show cause why an order should not issue directing the Employee to attend the appointment. (Section B of WC-PMTb). 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.

(3) Upon the filing of Section B of the WC-PMT or WC-PMTb, 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. Postponements will be discouraged and granted only for good cause shown. Any party requesting a postponement must contact the Board and obtain an alternate date which is within 5 business days of the original conference date and certify that the date is agreeable to the opposing party. 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 (WC-PMT) or why the employee has failed to attend the appointment (WC-PMTb). Failure of any party to participate in the conference does not preclude a ruling on the Petition.

(4) In lieu of participation in the telephonic conference requested by the PMT, 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. Upon completion and filing of the Authorization in Section

63 C or the Controvert in Section D of the WC-PMT, any scheduled telephonic conference is cancelled.

(5) In lieu of participation in the telephone conference requested by the WCPMTb, the employee or the employee's attorney may agree that the employee will attend the appointment by completing Section C of the WCPMTb. Upon completion, filing and proper service of the Agreement to Attend Medical Appointment in Section C of the WC-PMTb, any scheduled telephonic conference is cancelled. If the employee does not attend the appointment in accordance with an order of the Administrative Law Judge or the agreement by the employee or the employee's attorney that the employee will attend the appointment, the employer/insurer may file Section D of the PMTb requesting a telephone conference in accordance with the provisions of Rule 205(c)(3) during which the employee or the employee's attorney shall be directed to show cause why the employee's disability benefits should not be suspended.

(6) Following the telephonic conference, the Administrative Law Judge may issue an Interlocutory Order which addresses authorization of the treatment or testing at issue (WC-PMT), attendance at the medical appointment or suspension of the employee's disability benefits for failure to attend the medical appointment (WC-PMTb). 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.

(7) Any party objecting to an Interlocutory Order issued pursuant to this Rule 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.

(d)(1) If medical treatment is controverted on the grounds that the treatment is not reasonably necessary, the burden of proof shall be on the employer. If the treatment is controverted on the grounds that the treatment is either not authorized or is unrelated to the compensable injury, the burden of proof shall be upon the employee.

(2) In the event of a dispute as to the necessity and/or reasonableness of services already rendered, the procedure listed in Board Rule 203(c) shall be followed.

(e) If an employer or insurer utilizes a Board-certified WC/MCO pursuant to O.C.G.A. § 34-9-201(b)(2), and a dispute regarding authorization of treatment/testing prescribed by an authorized treating physician is not resolved within 30 days, then the employee or the employee's attorney may initiate the WC-PMT proceedings in subsection (c) of this Rule. Where no WC-PMT is filed, and the dispute is not resolved within 30 days as outlined in Rule 208(f), then the employer or insurer has 15 days from notification by the WC/MCO to authorize the treatment/test or controvert the treatment/test. In no event will the employer or insurer utilizing a WC/MCO have more than 45 days from the receipt of the notice of a dispute as set forth in Rule 208(f)

to comply with this provision.

Rule 206. Reimbursement of Group Carrier or Other Healthcare Provider.

(a) Only a party to a claim, a group insurance company or other healthcare provider who covers the costs of medical treatment or provides medical services to the employee may file a Form WC-206.
(b) Form WC-206, shall include supporting documentation and an explanation of any dispute and shall be submitted to the Board by the party seeking reimbursement during the pendency of the claim. Copies shall also be sent by the party requesting reimbursement to all counsel and unrepresented parties at interest.
(c) When the Board receives a request for reimbursement and designation as a party at interest, the Board will provide the requesting party with notice of any hearing at which the party at interest will be permitted to present evidence of its claimed interest.

Rule 208. Managed Care Organization Rules.

(a) Application and certification.

(1) All provisions of this Rule constitute the minimum requirements necessary to obtain and maintain certification as a WC/MCO under the Georgia Workers' Compensation Act. To obtain certification of a plan, application shall be submitted on a Form WC-208a accompanied by a non-refundable fee of $1,000.00 and shall include the following information:

(A) An audited financial statement evidencing the ability of the Managed Care Organization to comply with any and all financial requirements to insure the delivery of services the Board may prescribe.

(B) Complete disclosure should be made of the following individuals (an individual may act in more than one capacity):

(1) The names, addresses and resume of all directors and officers of the WC/MCO;

(2) The title, name, address, telephone number and resume of the person to be the day-to-day administrator of the WC/MCO;

(3) The title, name, address, telephone number and resume of the person to be the administrator of the financial affairs of the WC/MCO;

(4) The name, address, medical specialty and resume of the medical director;

(5) The name, address and telephone number of the WC/ MCO's communication liaison for the Board, the insurer, the employer, and the employee; and

(6) The name and address or any other information requested by the Board regarding any entity, other than individual health care providers, with whom the WC/MCO has a joint venture or other

agreement to perform any of the functions of the managed care plan, and a description of the specific function to be performed by each entity.

(C) The WC/MCO must insure provisions of quality services that meet all uniform treatment standards required by Georgia law and provide appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service.

(D) The WC/MCO must provide a description of its proposed geographic service area by county and specify the times, places and manner of providing services, including a statement describing how the WC/MCO will insure that an adequate number of each category of health care provider is available to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan.

(E) The WC/MCO must include minority providers, and at a minimum, the following types of health care services and providers, unless the WC/MCO provides evidence that a particular service or type of provider is not available in the geographical service area:

(1) Medical doctors, including specialists in at least one of the following fields: family practice, internal medicine, occupational medicine, or emergency medicine;

(2) Orthopedic surgeons, including specialists in hand and upper extremity surgery;

(3) Neurologists and neurosurgeons;

(4) General surgeons;

(5) Chiropractors;

(6) Physical and occupational therapists;

(7) Psychologists or psychiatrists;

(8) Diagnostic pathology and laboratory services;

(9) Radiology services; and

(10) Hospital, outpatient surgery, and emergency care services.

(F) The WC/MCO must submit sample copies of all types of agreements with providers who will deliver services under the WC/MCO and a description of any other relationships with providers who may deliver services to a covered employee.

(G) The WC/MCO must attach to each type of sample agreement a corresponding list of names, clinics, addresses and types of license and specialties for the health care providers with whom they have utilized the agreement.

(H) In all agreements with the WC/MCO and any other provider of services, the agreement shall contain the following provision: “It is the intent of the parties to this agreement to insure quality services that meet all uniform treatment standards required by Georgia law, and any provision herein which may be inconsistent with that intent shall be void.”

(I) The WC/MCO must submit a statement certifying that all licensing

requirements for the providers and medical case managers are current and in good standing in Georgia or the state in which the provider is practicing.

(J) The WC/MCO must provide a referral for specialty services that are not specified in subparagraph (E) and that may be reasonable and necessary to effect a cure or give relief as required under O.C.G.A. § 34-9-200.

The employer or the workers' compensation insurance carrier remains liable for any health service required under the Workers' Compensation Act, provided that the services meet all other requirements of the Workers' Compensation Act.

(K) The WC/MCO must include procedures to ensure that employees will receive services in accordance with the following criteria:

(i) The medical case manager shall inform the employee of his right to choose from the providers designated in Rule 208(a)(1)(E), inform the employee that a list of medical providers is available and provide assistance in obtaining the list if necessary. The medical case manager shall assist the employee in choosing a provider appropriate to the injury. The physician so chosen shall be deemed the “authorized treating physician” for all purposes under the Workers' Compensation Act. Employees must be allowed to change authorized treating physicians within the managed care plan at least once without proceeding through the managed care plan's dispute resolution process. In such cases, employees shall give notice to the manage care plan for a change in their authorized treating physician;

(ii) Employees must be able to receive information on a 24-hour basis regarding the availability of necessary medical services available within the managed care plan. The information may be provided through recorded toll-free telephone messages after normal working hours. The message must include information on how the employee can obtain emergency services or other urgently needed care and how the employee can access an evaluation within a reasonable time after request;

(iii) Employees must receive initial evaluation by a participating licensed health care provider within twenty-four hours after the employee's request for treatment, following a work-related injury;

(iv) In cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan, the employee must receive initial evaluation or treatment by a participating health care provider within five (5) working days of the employee's request for a change of doctor or referral to the managed care plan;

(v) Employees must receive any necessary treatment, diagnostic tests or specialty services in a manner that is timely, effective and convenient for the employee, and reasonable under the circumstances;

(vi) Employees must have reasonable access to health care providers. If the employee is medically unable to travel to a participating provider, the managed care plan shall refer the employee to an available or non-participating provider to receive necessary treatment for the injury.

(L) The WC/MCO must designate the procedures for approval of services from a health care provider outside the managed care plan.

(M) The WC/MCO must include a procedure for peer review and

utilization, consistent with Rule 208(g).

(N) The WC/MCO must include a procedure for internal dispute resolution, including a method to resolve complaints by injured employees, medical providers, employers and insurers.

(O) The WC/MCO must inform employees of all choices of medical services provided within the plan and how employees can gain access to those providers including but not limited to a wallet-sized card containing this information in a format suitable for carrying on the employee's person. The plan must submit a proposed publication which may be customized according to the needs of the employer but must include the information required in Rule 201(a)(3) and must also include a complete list of all WC/MCO medical providers in the applicable geographical service area. All employees of covered employers shall be provided with the publication.

(P) The WC/MCO must provide the information required by Rule 208(h) and describe how medical case management will be provided for injured employees, and an effective program for return-to-work and cooperative efforts by the employees, the employer and the managed care plan to promote workplace health and safety and other services.

(Q) The WC/MCO must provide such other information as the Board considers necessary to determine compliance with the Workers' Compensation Act.

(2) Within 60 days of receipt of an application, the Board must notify an applicant for certification of any additional information required or modification that must be made. The Board must notify the applicant in writing of the approval or denial of certification within 60 days of receipt of the additional information or modification. If certification is denied, the applicant must be provided, in writing, with the reason or reasons for the denial.

(3) Any person aggrieved by a denial of certification by the Board may make written request for a hearing within 30 days of the date the denial is served and filed. The Appellate Division shall hold all hearings and issue a final decision.

(b) Coverage responsibility of WC/MCO.

(1) A WC/MCO must contract with the employer or the workers' compensation insurer of an employer. In the event multiple WC/MCO's are contracted to cover the same employer, each employee shall have the initial election of the WC/MCO that will manage the employee's care, and utilization of a WC/MCO will be deemed an election.

(2) An employee who gives notice to an employer of a compensable injury shall receive medical services in the manner prescribed by the terms and conditions of the WC/MCO contract in effect at the time medical services are rendered.

(3) To insure continuity of care, the WC/MCO contract shall specify the manner in which an injured employee will receive medical services when a WC/MCO contract or contract with the health care provider terminates. The employee may continue to treat with the health care provider or the WC/MCO under the terminating contract until such time as the employee elects to utilize the employer's current posted panel of physicians, conformed panel of physicians or

WC/MCO, or a change of physician is granted.

(c) Reporting requirements for Board certified WC/MCO's.

(1) A WC/MCO shall provide the Board with a copy of the following contracts:

(A) Contracts between the WC/MCO and any employer or workers' compensation insurer, prior to utilization of the contract. If the Board does not issue a written approval or denial within 90 days, then the contract shall be approved. Any contract rejected by the Board shall be deemed void for purposes of this Rule. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts must include a list of signatories and a listing of all employers covered by each contract, including the employers' name, business address and estimated number of employees governed by the WC/MCO. Amendments and addendums to the contracts must be submitted to the Board within 30 days of execution. Contract provisions must be consistent with O.C.G.A. § 34-9-208 and this Rule. The contract must specify the billing and payment procedures and how the medical case management and return-to-work functions will be coordinated.

(B) New types of agreements between participating health care providers and the WC/MCO that are not identical to the agreements previously submitted to the Board shall not be effective until approved by the Board. Any contract which is neither approved nor rejected by the Board within 90 days from submission shall be deemed approved.

(C) Contracts between the WC/MCO and any entity, other than individual participating providers that performs some of the functions of the WC/MCO.

(D) Any changes in the individuals or information required by Board Rule 208(a)(1)(B)(1)-(5).

(2) In order to maintain certification, each WC/MCO shall provide on the first working day following each anniversary of certification the following information in the form of a certified annual report:

(A) A current listing of all individuals identified in Board Rule 208(a)(1)(B)(1)-(5) and all participating health care providers, including provider names, types of license, specialty, business address, telephone number and a statement that all licenses are current and in good standing;

(B) A summary of any sanctions or punitive actions taken by the WC/MCO against any participating providers;

(C) A report that summarizes peer review, utilization review, supplier profiles, reported complaints and dispute resolution proceedings showing cases reviewed, issues involved, and any action taken; and

(D) An audited financial statement for the most recent fiscal year, upon request of the Board.

(E) The annual report must be accompanied by a non-refundable fee of $500.00.

(3) Any proposed changes to the Board-certified WC/MCO falling within the categories enumerated below, other than changes to the health care provider list, may not be implemented under the plan until approved by the Board:

(A) Amendments to any contract with participating health care providers;

(B) Amendments to contracts between the WC/MCO and another entity performing functions of the managed care plan; and

(C) Any other amendments to the WC/MCO as certified.

(4) The WC/MCO must report to the employer or insurer any data regarding medical services and suppliers related to the workers' compensation claim required by the self-insured employer or insurer to determine compensability under the Workers' Compensation Act, and any other data required by the Board. The Board may require additional information from the managed care organization if the information is relevant to the Workers' Compensation Act.

(d) Commencement and termination of contract between the WC/MCO and participating providers.

(1) Prospective new participating health care providers under a WC/MCO shall submit an application to the WC/MCO. A director, executive director or administrator may approve the application under the requirements of the WC/MCO. The managed care plan shall verify that each new participating health care provider meets all licensing, registration and certification requirements necessary to practice in Georgia or other applicable state of practice.

(2) A participating provider may elect to terminate participation in the WC/MCO or to be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider contract, the managed care plan shall make alternate arrangements to provide continuing medical services for an affected injured employee under the plan in compliance with Board Rule 208(b)(3).

(e) A health care provider who is not a participating health care provider may provide medical services to an employee covered by a WC/MCO in any other circumstances provided below:

(1) Emergency treatment;

(2) When the employee is referred to the provider by the managed care organization;

(3) By order of the Board, or by consent of the parties.

(f) Disputes which arise on an issue related to managed care shall first be processed without charge through the dispute resolution process of the WC/MCO. The WC/MCO dispute resolution process must be completed within 30 days of a written notice. If the dispute cannot be resolved, the WC/MCO must immediately notify the employer or insurer. If the dispute involves treatment/test prescribed by the authorized treating physician, the employer or insurer must follow the procedure outlined in Rule 205.

(g) Utilization review and peer review.

(1) The WC/MCO must implement a system for peer review to improve patient care and cost effectiveness of treatment. Peer review must include a majority of health care providers of the same discipline being reviewed. The peer review must be designed to evaluate the quality of care given by a health care provider to a patient or patients. The plan must describe in its application for certification how the providers will be selected for review, the nature of the review and how the results will be used.

(2) The WC/MCO must implement a plan for utilization review. The program must profile each medical supplier and include the collection, review, analysis of group data (utilizing CPT-4 codes) to improve overall quality of care, efficient use of resources and duration of disability. In its application for certification, the WC/MCO must specify the data that will be collected, how the data will be analyzed and how the results will be applied to improve patient care and increase cost effectiveness of treatment.

(h) Medical case management.

(1) The medical case manager must monitor, evaluate and coordinate the delivery of quality, cost effective medical treatment and other health services needed by an injured employee, and must promote an appropriate, prompt return to work. Medical case managers must facilitate communication between the employee, employee's representative, employer, employer's representative, insurer, health care provider, WC/MCO and, when authorized, any qualified rehabilitation consultant to achieve these goals. The WC/MCO must describe in its application for certification how injured employees will be subject to case management, the services to be provided, and who will provide services.

(2) Case management for an employee covered by a WC/MCO must be provided by a licensed registered health care professional holding one of the following certifications: Certified Rehabilitation Registered Nurse (CRRN), Certified Case Manager (CCM), Certified Occupational Health Nurse (COHN), Certified Occupation Health Nurse Specialist (COHN-S), Certified Disability Management Specialist (CDMS), Certified Rehabilitation Counselor (CRC), Work Adjustment/Vocational Evaluation Specialist (WAVES), or Licensed Professional Counselor (LPC). Case managers must have at least one year experience in workers' compensation. In catastrophic cases, case management must include assignment to a Board-registered rehabilitation supplier, who has been designated by the board as qualified to manage catastrophic cases (Rule 200.1 (f)(4)). If qualified, the case manager may register with the Board to serve as the catastrophic rehabilitation supplier.

(3) The parties to the claim and their representatives shall cooperate with medical case management services when such services are being provided by a WC/MCO which has been certified pursuant to O.C.G.A. § 34-9-208 and Board Rule 208 and which has posted a WC-P3 panel. The unreasonable refusal to cooperate with or the unreasonable interference with medical case management services by any party or its representative may subject that party or its representative to civil penalties pursuant to O.C.G.A. § 34-9-18. The employer/insurer may suspend weekly benefits for the failure of the employee to cooperate with medical case management only by order of the Board.

(i) Monitoring records.

(1) The Board shall monitor and may conduct audits and special examinations of the WC/MCO as necessary to insure compliance with the WC/MCO certification and performance requirements.

(2) All records of the WC/MCO and its participating health care providers relevant to determining compliance with the Workers' Compensation Act shall be disclosed in a reasonable time after request by the Board. Records must be legible and cannot be kept in a coded or semi-coded manner unless a ledger is provided

for codes.

(3) The release of records filed with the Board must clearly identify the portions of the application or records which are believed to be non-public trade secret data or otherwise confidential.

(j) Suspension; revocation.

(1) The WC/MCO shall work with all parties and their representatives in a reasonable manner consistent with the purposes of this Act. Complaints pertaining to violations by the WC/MCO shall be directed in writing to the Board. Upon receipt of a written complaint or after monitoring the managed care plan operation, the Board shall investigate the alleged violation. The investigation may include, but shall not be limited to, requests for and review of pertinent managed care records. If the investigation reveals reasonable cause to believe that there has been a violation warranting suspension or revocation of certification, the Board shall schedule a hearing.

(2) The certification of any WC/MCO issued by the Board may be suspended or revoked, in the discretion of the Board, if the WC/MCO fails to meet any of the requirements of O.C.G.A. § 34-9-208 or Board Rule 208.

(3) For purposes of this Rule, “suspension” and its variations means the cessation of the WC/MCO's authority to enter into new contracts with employers or insurers for a specified period of time up to a maximum of one (1) year. Upon suspension, the WC/MCO may continue to provide services in accordance with the contracts in effect at the time of the suspension. A suspension may be set aside prior to the end of the designated suspension period if it is shown to the satisfaction of the Board that the WC/MCO is in compliance. Furthermore, if it is shown that the WC/MCO is not in compliance immediately prior to the end of the designated suspension period, the suspension may be extended without further hearing, or revocation proceedings may be initiated.

(4) For purposes of this Rule, “revocation” and its variations means a revocation of a WC/MCO's certification to provide services under these Rules. If the WC/MCO certification is revoked, no employee is covered by the contract between the WC/MCO and the employer or workers' compensation carrier. However, upon revocation of certification, the WC/MCO may continue to provide services under contracts in effect to the extent the Board determines that it is necessary for injured employees to continue to receive medical services in that manner.

(5) Suspension or revocation under this Rule will not be made until the WC/MCO has been given notice and the opportunity to be heard through a show-cause hearing before the Board. The Board shall provide the WC/MCO written notice of an intent to suspend or revoke the WC/MCO's certification and the grounds for such action. The notice shall also advise the WC/MCO of the right to participate in the show-cause hearing and specify the date, time and place of the hearing. The notice shall be issued from the Board at least twenty-one (21) days prior to the scheduled date of the hearing. After the show-cause hearing, the Board may issue a final order suspending or revoking the WC/MCO's certification.

(6) Upon revocation of a WC/MCO's certification, the employer or the workers' compensation insurer of an employer with whom the revoked WC/MCO had been contracted to provide managed care shall make alternate arrangements to provide continuing medical services for injured employees who had been

receiving medical care through the revoked WC/MCO. Any injured employee receiving medical services through a WC/MCO prior to revocation of the WC/MCO's certification may continue to treat with one of the individual health care providers with whom the employee had received medical services prior to revocation until such time as the employee elects to utilize the employer's replacement posted panel of physicians, conformed panel of physicians or WC/MCO, or a change of physician is ordered.

Rule 220. Computing Days of Disability Preceding Payment of Compensation.

(a) 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 shall begin the next day following the date of injury.

(1) The day or days considered lost because of disability to work shall be counted from the first seven calendar days of disability even though the days may not be consecutive.

(2) Intervening days, which are not scheduled workdays, during disability or preceding a return to work, are days of disability.

(3) Disability shall end on the day of the return to work.

(b) 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.

(c) An injured employee who receives regular wages during disability shall not be entitled to weekly benefits for the same period.

Rule 221. Method of Payment.

(a) Payment shall be made to the address of record or account specified by the claimant, in cash, by negotiable instrument, or upon agreement of the parties by electronic funds transfer. Payment by negotiable instrument shall denote the pay period which the payment represents. Mailed payments shall be sent to the claimant in accordance with the procedure prescribed by O.C.G.A. §34-9-221(b).

(b) For the purpose of calculating time periods, the date of injury shall be deemed to be the date of disability and a week shall be deemed to be seven calendar days. See Rule 220(a).

(c) In all cases, including payment of salary for compensable disability, upon making the first payment and upon suspension of payment, Forms WC-1 or WC-2 or, in case of death, Form WC-2A shall be filed with the Board. If the Forms WC-1 or WC-2 show payment is less than the maximum weekly benefit under either O.C.G.A. §34- 9-261 or O.C.G.A. §34-9-262, as applicable, a Form WC-6 or other sufficient explanation shall be filed with the Board with the accompanying Form WC-1 or WC-2. To report any change in weekly benefits, payment of salary during period of compensability, classification, or rating of disability, a Form WC-2 shall be filed with the Board. An injured employee who receives regular wages during disability shall not be entitled to weekly benefits for the same period.

(d) To controvert in whole or in part the right to income benefits or other

compensation, use Forms WC-1 or WC-3. Failure to file the Forms WC-1 or WC-3 before the 21st day after knowledge of the injury or death may subject the employer/ insurer to an assessment of penalties or attorney's fees. See paragraphs (2) and (3) of subsection (b) of O.C.G.A. § 34-9-108.

(e) Any penalty for late payment shall be stated as a separate item on Forms WC-1, WC-2 or WC-2A.

(f) Accrued benefits payable under the terms of an award are due on the date the award is issued.

(g) Within 30 days after final payment of compensation, a final Form WC-4 shall be filed with the Board.

(h) Subsection (h) of O.C.G.A. § 34-9-221 applies only when income benefits are being paid under Forms WC-2, WC-2A, or subsection B of Form WC-1. To suspend payment on the ground of a change in condition, file Forms WC-2 or WC-2A.

(1) A Form WC-3 shall not be used to suspend benefits where the only issue is length of disability. In these cases, suspend benefits by filing a Form WC-2 or follow procedure outlined in Rule 240. If liability is denied subsequent to commencement of payment, but within 60 days of due date of first payment of compensation, file Form WC-3 in addition to a Form WC-2.

(2) If income benefits have been continued for more than 60 days after the due date of first payment of compensation, benefits may be suspended only on the grounds of a change in condition or newly discovered evidence. File Forms WC-2 or WC-2A. When controverting a claim based on newly discovered evidence, file Form WC-3 also.

(i) (1) Suspension of benefits at any time on the ground of change in condition requires advance notice of 10 days unless the employee has actually returned to work.

(2) The date of filing with the Board, in the absence of compelling evidence to the contrary, shall be considered the date of notice.

(3) The date affixed by the Board to Forms WC-2 or WC-2A, in the absence of compelling evidence to the contrary, shall be considered the date of notice.

(4) (a) When suspending benefits for release to return to work without restrictions, the employer/insurer shall attach to the Form WC-2 a copy of the supporting medical report from employee's authorized treating physician, who must have examined the employee within sixty days of the effective date of the release.

(b) If suspending benefits for release to return to work without restrictions, and if filing via EDI, section (i)(4)(a) shall be followed and the employer /insurer shall simultaneously mail to, or electronically file with, the Board the filed Subsequent Report of Injury (SROI) or Form WC-2 and a copy of the supporting medical report from employee's authorized treating physician. Pursuant to Board Rule 60(c), all documents filed with the Board shall contain the employee’s name, date of injury, and Board claim number. Any document 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. If service is performed by regular mail to the employee, three

additional days shall be added to the prescribed notice period.

Rule 222. Time Limit for Application for Lump Sum Payment.

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

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

(1) A request for a lump sum 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 request will not be granted unless the current Form WC-25 is completely filled out with appropriate supporting documents as directed on the form.

(2) The parties have 15 days from the date of the certificate of service to file objections to the application. Objections to applications for lump sum advances shall be submitted on Form WC-25 and 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. A certificate of service must accompany the objections attached.

(3) 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 of 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 an extension is granted by the Board upon a showing of just cause.

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

(5) The maximum amount of attorney fees which will be awarded in conjunction with an advance will be 25 percent of the amount of the advance or $500.00, whichever is less, unless specifically authorized by the Board. In the event the attorney obtaining the advance has a fee contract that has been previously approved by order or award of the Board, attorney fees will be authorized in accordance with the terms of the order or award.

Rule 226. Procedures for Appointing Conservator for Minor or Incompetent Adult.

(a) A petition for the Board to appoint a temporary conservator to bring or defend an action under this chapter and/or to receive and administer workers' compensation benefits for a minor or incompetent adult should be filed with the Board at the time the WC-14 is filed. In the case of any stipulated settlement, a

conservatorship petition shall be filed prior to, and separately from, the filing of a stipulated settlement agreement.

If payment to the minor or incompetent adult is pursuant to a WC-2, the conservatorship petition should be filed with the Board and a conservator appointed prior to the payment of any monetary benefits to them.

(b) Any applicant for conservatorship shall consent to a criminal history record check at the time the petition for conservatorship is submitted to the Board via a Form WC-226(a) or Form WC-226(b). In addition, the applicant shall attach supporting documentation necessary to process the request.

(c) If a petition is filed on behalf of a minor child or children, the petitioner shall inform, in writing, the Board whether the minor child or children reside with the petitioner.

(d) If a petition is filed with the Probate Court or any other court, the parties are directed to immediately notify, in writing, the Board. If the Probate Court or any other court appoints a conservator, the parties shall file a copy of the order with the Board.

(e) (1) All objections shall be made on Form WC-102D. When attaching documents as evidence to objections, do not use tabs to separate documents.

(2) Any party or attorney filing a request or objection shall also serve a copy on all counsel and unrepresented parties, along with supporting documents, including a separate certificate of service identifying the names and addresses served.

(3) When filing a motion for reconsideration, the parties or attorneys shall:

(1) Immediately notify the Board or assigned Administrative Law Judge by telephone call;

(2) Use the ICMS doc-type labeled motion for reconsideration; and (3) serve a copy on all counsel and unrepresented parties, along with supporting documents, including a separate certificate of service identifying the names and addresses served.

Rule 240. Offer of Suitable Employment.

(a) For suspension and reinstatement of income benefits by interlocutory order generally, see Board Rule 102D.

(b) When an employee unjustifiably refuses to accept employment which has been approved by the authorized treating physician(s) suitable to his/her impaired condition and offered to the employee in writing, the employer/insurer may suspend payment of income benefits to that employee without an order of the Board in the following manner:

(1) File with the Board a Form WC-2 and Form WC-240 certifying that at least ten days before the employee was required to report for work he/she was notified on the completed Form WC-240 mailed to the employee and his/her attorney that there was a suitable job available, that it was approved by his/her authorized treating physician(s) after an examination within the last 60 days, and refusal to attempt to perform the job would result in the suspension of payment of weekly income benefits to the employee. The employer/insurer shall

provide to the employee and legal counsel a copy of any job description/analysis in reference to subparagraph (3)(i), (ii) and (iii) at the time of submission to the authorized treating physician(s).

(2) If filing via EDI, section (b)(1) shall be followed and the employer/insurer shall simultaneously mail to, or electronically file with, the Board the filed Subsequent Report of Injury (SROI) or Form WC-2 and a copy of the served Form WC-240 and supporting medical report from employee's authorized treating physician. Pursuant to Board Rule 60(c), all documents filed with the Board shall contain the employee's name, date of injury, and Board claim number. Any document 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.

(3) Attached to the Form WC-240 shall be:

(i) A description of the essential job duties to be performed, including the hours to be worked, the rate of payment, and a description of the essential tasks to be performed;

(ii) The written approval of the authorized treating physician(s) of the essential job duties to be performed;

(iii) The location of the job, with the date and time that the employee is to report to work.

Attaching a properly completed Form WC-240A will satisfy the requirements for making a proper offer of employment as set forth herein.

(4) If the employee attempts the proffered job for less than eight cumulative hours or one scheduled workday, whichever is greater, or refuses to attempt to perform the proffered job after receiving the above notification, the employer/insurer shall be authorized to suspend payment of income benefits to the employee effective the date that they unjustifiably refused to report to work.

(c) Should the employee accept the employment offered by the employer/insurer and attempt the proffered job for eight cumulative hours or one scheduled workday, whichever is greater, but fail to continue working for more than the prescribed fifteen (15) scheduled work days, the employer/insurer, whether or not they have sent a WC-240, shall immediately reinstate payment of income benefits and shall file with the Board and serve upon the employee the appropriate Form WC-2 reflecting the reinstatement of income benefits.

(i) Failure to immediately reinstate benefits pursuant to Board Rule 240 (c), shall result in the waiver of the employer/insurer's defense of the suitability of employment for the period of time the employer/insurer did not pay the employee's weekly income benefits when due.

(ii) When the employer/insurer immediately reinstates benefits pursuant to Board Rule 240 (c), the employer/insurer are entitled to seek reimbursement of such benefits at a hearing addressing the suitability of the proffered employment.

(d) When calculating the fifteen (15) scheduled work days provided by statute, the employer/insurer shall include as a work day each day or part thereof during which the employee is scheduled to perform his/her job duties.

(e) The employer/insurer shall also be entitled to suspend payment of weekly

benefits to the employee pending a hearing by an order of the Board finding an unjustifiable refusal of the employee to accept employment procured for him/her suitable to his/her capacity. A motion requesting this order may be made simultaneously with the filing of a request for hearing or at any time during the pendency of the hearing and award and shall be filed on Form WC-102D, and must be accompanied by an affidavit from the employer setting forth that suitable employment has been offered to the employee as set forth in (b) above, the offer is continuing, and analysis of the job is attached. The employer/insurer shall have the employee examined by the authorized treating physician(s) within 60 days prior to this request for suspension of income benefits. No request for suspension of income benefits for failure to accept suitable employment shall be granted unless the authorized treating physician(s) approve(s) the job offered by the employer/insurer. A party who objects to this motion shall file their response on Form WC-102D with the Board within 15 days of the date of the certificate of service on the request and shall serve a copy on all counsel and unrepresented parties.

(f) The Board may also issue an interlocutory order reinstating weekly income benefits pending a hearing. A party making this motion shall file Form WC-102D, and shall serve a copy, along with a copy of supporting documents, on all counsel and unrepresented parties. A motion requesting this order may be made simultaneously with the filing of a request for hearing based on a change in condition or at any time during the pendency of the hearing and award and must be accompanied by an affidavit of the employee setting forth his contentions, along with current medical records when applicable. A party who objects to this motion shall file Form WC-102D with the Board within 15 days of the date of the Certificate of Service on Form WC-102D and shall serve a copy on all counsel and unrepresented parties.

(g) In the event the employee's weekly benefits are suspended pursuant to O.C.G.A. §34-9-240(b)(2), the employer/insurer shall comply with O.C.G.A. §34-9-263 and Board Rule 263.

Rule 243. Credit for Payment of Income Benefits.

An employer /insurer seeking a credit as provided by O.C.G.A. § 34-9-243 shall file with the Board Form WC-243, and shall report on Form WC-243 the amount of unemployment compensation and/or weekly income payments made on behalf of an employee pursuant to a disability plan, a wage continuation plan, or a disability insurance policy and shall set forth the ratio of the employer's contributions to the total contributions of such plan or policy no later than 10 days prior to a hearing. A copy of this form shall be sent to all counsel and unrepresented parties by the employer/insurer at the same time that it is filed with the Board.

Rule 244. Reimbursement for Payment of Disability Benefits.

(a) A provider of disability benefits who requests reimbursement shall file Form WC-244 with the Board, and shall serve a copy on all counsel and unrepresented parties.

(b) Form WC-244 shall provide supporting documentation, including the policy/plan provision authorizing the provider to obtain reimbursement, and an explanation of any dispute and shall be submitted to the Board by the party seeking reimbursement during the pendency of the claim.

Rule 260. Basis for Computing Compensation.

(a) Computation of wages shall include, in addition to salary, 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 pecuniary calculation.

(b) Unless the contrary appears, it is assumed that a normal workweek 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 proportionately 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.

(c) If the employee has similar concurrent employment the wages paid by all similar concurrent employers shall be included in calculating the average weekly wage.

Rule 261. Reserved.

Rule 262. Computing Temporary Partial Disability.

(a) The average weekly wage the employee is able to earn after the injury may be determined according to the method of computation in O.C.G.A § 34-9-260(1).

(1) An employer/insurer using this method may recompute the average weekly wage after payment of benefits begin under O.C.G.A. § 34-9-262 and at 13-week intervals thereafter.

(2) In lieu of calculating an average weekly wage after injury based on 13-week intervals, the employer/insurer may elect to calculate benefits due each week by multiplying two-thirds times the difference between the average weekly wage on the date of injury and the actual weekly wage the employee earned each week thereafter.

(b) For the purposes of calculating temporary partial benefits as contemplated by O.C.G.A. § 34-9-104(a)(2), see method of calculation set forth in O.C.G.A. § 34-9- 104(a)(3).

(c) When paying weekly temporary partial disability income benefits based on an actual return to work, file a Form WC-262 with the Board at 13 week intervals or when such benefits are suspended, whichever comes first. When filing the Form WC-262 with the Board, send a copy to the employee and the employee’s counsel, if represented.

Rule 263. Determination of Disability Rating.

When the employee is no longer receiving weekly benefits under O.C.G.A. §34-9-261 or §34-9-262, and a permanent partial disability (PPD) rating has not previously been requested or issued, the employer/insurer shall have thirty days to request, in writing, from an authorized physician, that the employee be rated in accordance with the "Guides to the Evaluation of Permanent Impairment, Fifth Edition," published by the American Medical Association. The employer/insurer shall furnish a copy of the medical report of rating to the employee, and commence payment not later than 21 days after knowledge of the rating. The employer/insurer are presumed to have knowledge of the rating not later than 10 days after the date of the report establishing the rating.

Rule 265. Payment of No-Dependency Benefits Into the General Fund of the State Treasury.

The insurer or self-insurer in no-dependency death cases, shall pay to the State Board of Workers' Compensation the amount set forth in Code Section 34-9-265(b).

Rule 380. Establishment of the Self-Insurers Guaranty Trust Fund.

Rule 381. Definitions as used in this Article.

(a) "Applicant" means an employee entitled to workers' compensation benefits.
(b) "Board" means the State Board of Workers' Compensation.
(c) "Board of trustees" means the Board of trustees of the Fund.
(d) "Company" means a corporation, association, partnership, proprietorship, firm or other form of business organization.
(e) "Fund" means the Self-Insurers Guaranty Trust Fund.
(f) "Insolvent self-insurer" means a self-insurer who files for relief under the Federal Bankruptcy Act, a self-insurer against whom involuntary bankruptcy proceedings are filed, a self-insurer for whom a receiver is appointed in a federal or state court of this state or any other jurisdiction or a self-insurer who is in default on workers' compensation obligations; or a self-insurer who is determined by the Board to be in noncompliance with workers compensation obligations or requirements according to rules and regulations of the Board.
(g) "Participant" means a self-insurer who is a member of the Fund.
(h) "Self-insurer" means a private employer, including any hospital authority created pursuant to the provisions of Article 4 of Chapter 7 of Title 31, the "Hospital Authorities Law," that has been authorized to self-insure its payment of workers' compensation benefits pursuant to this Chapter, except any governmental self-insurer or other employer who elects to group self-insure pursuant to Code Section 34-9-152, or captive insurers as provided for in Chapter 41 of Title 33, or employers who, pursuant to any reciprocal agreements or contracts of indemnity executed prior to March 8, 1960, created funds for the purpose of satisfying the obligations of self-insured employers under this chapter. A "self-insurer" shall further not include any individual or company who enters into a contract or agreement with an employer under which the employer outsources its workers' compensation risks,

responsibilities, obligations or liabilities to such individual or company; and pursuant to such contract or agreement, is required to provide workers' compensation benefits to an injured employee even though no common-law master-servant relationship or contract of employments exists between the injured employee and the individual or company providing the benefits.

(i) "Trustee" means a member of the Self-Insurers Guaranty Trust Fund Board of Trustees.

Rule 382. Purpose.

(a) The purpose of creating a Self-Insurers Guaranty Trust Fund is to make payments in accordance with this chapter for the benefit of workers injured on the job in the event a participant becomes insolvent. The Fund shall be administered by an administrator appointed by the Chairperson of the Board of trustees with approval of the Board of trustees. The fund assets shall be invested only in obligation issued or guaranteed by the United States government.

(b) All returns on investment shall be retained by the Fund. In addition to paying benefits, and administrative fees, operating costs of the fund, attorneys' fees incurred by the Board of trustees and other costs reasonably incurred by the Board will be paid from this Fund.

(c) As a condition of self-insurance all private employers must make application and be accepted in the Self-Insurers Guaranty Trust Fund.

(d) Membership in the Fund shall not be permitted for any of the following:

(1) Any governmental employer authorized by the Board to self-insure:

(2) Any employer who elects to group self-insure pursuant to Code Section 34-9-152;

(3) Captive insurers as provided for in Chapter 41 of Title 33;

(4) Any employer who, pursuant to any reciprocal agreements or contracts of indemnity executed prior to March 8, 1960, created funds for the purpose of satisfying the obligations of self-insured employers under this chapter;

(5) Any individual or company who enters into a contract or agreement with an employer under which the employer outsources its workers' compensation risks, responsibilities, obligations or liabilities to such individual or company; and pursuant to such contract or agreement, is required to provide workers' compensation benefits to an injured employee even though no common-law master-servant relationship exists between the injured employee and the individual or company providing the benefits.

(e) Self-insurers must give written notice to the Board when they add or delete subsidiaries, affiliates, divisions or locations to their self-insurance certificate, or make any changes in their excess insurance policies. (See Rule 126(c).)

Rule 383. Board of Trustees; How Appointed.

(a) Each member of the Board of trustees shall be an employee of a participant. The Board of trustees shall consist of a chairperson and six trustees elected by the participants. The Board of trustees shall initially be appointed by the Governor not later than August 1, 1990. Three of the initial trustees shall be

appointed for terms of office which shall end on January 1, 1993, and the chairperson and the three other initial trustees shall be appointed for terms of office which shall end on January 1, 1995. Thereafter, each trustee shall be elected to a four-year term and shall continue to serve unless otherwise ineligible under subsection (b) of this Code section. No later than 90 days prior to the end of any member's term of office, the chairperson shall select a nominating committee from among the participants to select candidates for election by the participants for the following term. In the event the chairperson fails to complete his or her term of office, a successor will be elected by the Board of trustees to fill the unexpired term of office.

(b) A vacancy in the office of the Board of trustees shall occur for the following reasons:

(1) Resignation;
(2) Death;
(3) Conviction of felony;
(4) Employer no longer qualifies as a self-insured participant;
(5) Trustee is no longer an employee of the participant.

(c) The Board of trustees may remove any trustee from office for:

(1) Formal finding of incompetence;
(2) Neglect of duty; or
(3) Malfeasance in office.

(d) The Board of trustees, within 30 days after the office of any elected member becomes vacant, shall elect a successor for the unexpired term.

Rule 384. Powers of the Board of Trustees.

The Board of trustees shall possess all powers necessary to accomplish objectives prescribed in this article including the following:

(a) Submit to the Board, for approval within 90 days from appointment, bylaws, rules, regulations, resolutions and application fee of $500.00. Board of trustees may carry out its responsibilities by contract or other instrument; may purchase services, borrow money, purchase excess insurance, levy penalties and fines, and collect funds necessary to effectuate its activities. The Board of trustees shall appoint, retain and employ staff necessary to achieve the purposes of the Board of trustees with expenses incurred paid from the Fund.

(b) The Board of trustees shall meet quarterly or upon the call of the chairman issued to the trustees in writing not less than 48 hours prior to the day and hour of the meeting; upon a request submitted to the chairman 72 hours prior to the proposed day and hour by a majority of the trustees whereupon the chairman will provide notice as set forth above or by unanimous written agreement of the trustees.

(c) Any trustee may participate in a meeting of the board of trustees by telephone conference or similar communications technology which allows all individuals participating in the meeting to hear and speak with each other. Participation in a meeting pursuant to the subparagraph shall constitute presence at such meeting.

(d) Four trustees constitute a quorum.

(e) The Board of trustees shall serve without compensation; each member will be entitled to reimbursement for actual expenses incurred in the discharge of his official duties.

(f) The Board of trustees shall have the right to bring and defend actions in the name of the Fund. The administrator, the trustees, employers, agents, and employees shall not be liable jointly or individually for matters arising from or out of authorized conduct of the Fund in accordance with this article.

Rule 385. Participant Filing for Relief Under the Federal Bankruptcy Act.

(a) Within 30 days of the occurrence of filing for relief under the Federal Bankruptcy Act or against whom bankruptcy proceedings are filed or for whom a receiver is appointed, the participant shall file a written notice with the Board and the Board of trustees.

(b) Any individual who files an application for adjustment of a claim against a participant who is or becomes an insolvent self-insurer shall file a written notice of such participant's status with the Board and the Board of trustees within 30 days of such individual having knowledge of the participant becoming an insolvent insurer.

(c) Upon receipt of any notice as provided in subsections (a) and (b) of this Code Section, the Board shall determine whether the participant is an insolvent self-insurer. The Board of trustees shall refer for investigation all facts, circumstances, and information in its possession to a properly designated authorized certified public accountant for determination of the question of insolvency according to generally accepted accounting principles. Upon receipt of the notice referenced herein, a participant shall be required to execute a release of any and all financial information, banking records, books of account, tax returns or other records determined by the Board of trustees to be necessary in making a determination of insolvency and the participant shall assist in the production of said information when requested to do so by the Board of trustees.

(d) When a participant is determined to be an insolvent self-insurer, the Board of trustees is empowered and shall assume on behalf of the participant the following:

(1) Outstanding workers' compensation obligations excluding penalties, fines and claimant's attorney fees assessed pursuant to § 34-9-108(b).

(2) Responsibility for taking necessary steps to collect, recover, and enforce all outstanding security, indemnity, insurance, or bonds for the purpose of paying outstanding and continuing obligations of participants.

(3) Refunding any funds remaining from such security to the appropriate party one year from the date of final payment, provided no liabilities remain against the Fund and all applicable statutes of limitation have run.

(e) The fund shall be a party in interest in all proceedings in the payment of workers' compensation claims for a participant and shall be subrogated to the rights of the participant. The Fund may exercise all rights and defenses of the participant including:

(1) Appear, defend and appeal claims.

(2) Receive notice of, investigate, adjust, compromise, settle and pay claims.

(3) Investigate, handle, and controvert claims.

(f) Should payment of benefits be stayed in bankruptcy court, the Board of trustees or a designated representative shall appear in the bankruptcy court and move to lift the stay.

(g) The Board of trustees shall notify all employees with pending claims of the name, address and telephone number of the party administering and defending against their claim.

(h) The Board has the discretion to direct the Fund to pay, in whole or in part, the contractual fee arrangement between an attorney and a claimant pursuant to § 34-9-108(a). The attorney must apply to the Board and provide notice to the employee with a pending claim. Any party may make an objection to the application and all objections will be considered by the Board.

(i) This code section shall not impair any claims, to the extent those claims are unpaid, in the insolvent self-insurer's bankruptcy by the board of trustees, any employees, or any provider of services related to the insolvent self-insurer's workers' compensation obligations, to the extent those claims remain unpaid. Provider of services includes, but is not limited to, medical providers or the attorneys representing the insolvent self-insurer or the claimant, if the services provided are related to the insolvent self-insurer's workers' compensation obligations.

Rule 386. Method of Assessment.

(a) (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, 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 assessment of each participant shall be made on the basis of a percentage of the total of indemnity 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 indemnity benefits paid by that participant during the previous calendar year or $2,000.00, whichever is greater. The maximum amount of annual assessments, not including those special assessments provided for in paragraph (4) of this subsection, in any calendar year against any one 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 in an amount sufficient to increase the funded level of $5 million net of all liabilities; provided however, that such assessment in any calendar year against any one participant shall not exceed $8,000.00.

(5) Funds obtained by such assessment shall be used only for the purposes set forth in this article and shall be deposited upon receipt by the Board of trustees into the fund. If payment of any assessment, penalty or fine made under this article is not made within 30 days of the sending of the notice to the participant, the Board of trustees is authorized to do any or all of the following:

(A) Levy fines or penalties

(B) Proceed in court for judgment against the participant, including the amount of the assessment, fines, penalties, the costs of suit, interest, and reasonable attorneys' fees;

(C) Proceed directly against the security pledged by the participant for the collection of same; or

(D) Seek revocation of the participant's self-insured status.

(b) (1) The Fund shall be liable for claims arising out of injuries occurring after January 1, 1991; provided, however, no claim may be asserted against the Fund until the funding level has reached $1.5 million.

(2) All participants shall be required to maintain surety bonds or the Board of trustees may, in its discretion, accept an irrevocable letter of credit in the amount of no less than $250,000.00. In addition, each active participant shall be required to purchase excess insurance for statutory limits with a self-insured retention specified by the Board, and the excess policy shall include the bankruptcy endorsement required by the board and Board of trustees. For participants who are no longer active, security in an amount commensurate with their remaining exposure, as determined by the board, shall be required until all self-insured claims have been closed and all applicable statutes of limitations have run.

(c) A participant who ceases to be a self-insurer shall be liable for any and all assessments, penalties and fines made pursuant to this code section for so long as indemnity or medical benefits are paid for claims which originated when the participant was a self-insurer. Assessments of such a participant shall be based on the indemnity benefits paid by the participant during the previous calendar year.

(d) Upon refusal to pay assessments, penalties, or fines to the Fund or upon refusal to comply with a board order, the Fund may treat the self-insurer as being in default with this Chapter and the self-insurer shall be subject to revocation of its Board authorization to self-insure and forfeiture of its security.

Rule 387. Rights and Obligations of Board of Trustees to Obtain Reimbursement from Participant.

(a) The Board of trustees shall have the right and duty to obtain reimbursement from any participant for compensation obligations in the amount of the participant's compensation obligations assumed by the Board of trustees and paid for claims as well as reasonable administrative and legal costs. The amount of the claims for reimbursement of reasonable administrative and legal costs shall be approved by the Board of trustees.

(b) The Board of trustees shall have the right to use the security deposit of a participant, its excess insurance coverage, and any other guarantee to pay the

participant's workers' compensation obligations assumed by the Board of trustees including reasonable administrative and legal costs. The amount of the claims for reimbursement of reasonable administrative and legal costs shall be subject to the approval of the Board of trustees.

(c) The Board of trustees shall be a party in interest in any action or proceeding to obtain the security deposit of a participant for the payment of the participant's compensation obligations, in any action or proceeding under the participant's excess insurance policy, and in any other action or proceeding to enforce an agreement of any security deposit; or captive or excess insurance carrier; and from any other guarantee to satisfy such obligations. The fund is authorized to file a claim against an insolvent participant or the participant's agents and seek reimbursement for any payments made by the fund on behalf of the participant pursuant to this chapter. The fund is subrogated to the claim of any employee whose benefits are paid by the fund. Further, the find shall have a lien against any reimbursement payments the participant is entitled to from the Subsequent Injury Trust fund in an amount equal to the payments made by the fund to satisfy the participant's liability for workers' compensation benefits.

Rule 388. Duties of the Board to Board of Trustees.

(a) Report to Board of trustees when the Board has cause to believe participant examined may be in danger of insolvency.

(b) The Board shall, at the inception of the participant's self-insured status and at least annually thereafter, so long as the participant remains self-insured, furnish the Board of trustees with a complete, original bound copy of each participant's audited annual financial statement performed in accordance with generally accepted accounting standards by an independent certified public accounting firm, three to five years of loss history, name of the individual or company to administer claims, and any other pertinent information submitted to the Board to authenticate the participant's self-insured status. The Board of trustees may contract for the services of a qualified certified public accountant or firm to review, analyze, and make recommendations on these documents. All financial information submitted by a participant shall be considered confidential and not public information.

(c) The Board of trustees shall make reports and recommendation to the Board on any matter germane to solvency, liquidation or rehabilitation of any participant. Reports and documents shall not be considered public documents.

(d) The Board of trustees shall review all applications and shall make recommendations to the Board for acceptance of self-insurers. If the Board rejects the recommendations of the Board of trustees, the Board shall notify the Board of trustees in writing within ten days prior to accepting the application for self-insurance.