

**GEORGIA WORKERS' COMPENSATION**

**MEDICAL PROVIDERS' MANUAL**

**2001**

Prepared By:

Chairman's Workers' Compensation Advisory Council  
Public Education Committee  
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The Public Education Committee of the Chairman's Workers' Compensation Advisory Council is dedicated to assisting the State Board of Workers' Compensation in its efforts to provide ongoing educational information to the system participants. This manual is a compilation of various written materials submitted by members of that committee specifically designed to assist the medical providers in the system. Special thanks and acknowledgment are extended to the following authors:

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For many years participants in the workers' compensation system have commented that the medical providers who choose to treat workers' compensation patients need some guidance in understanding the workers' compensation rules and regulations. Many medical providers have also indicated a desire to have a tool to assist them in understanding the system. The various members of the Chairman's Advisory Council have also discussed the need for such a tool. Therefore, the Public Education Committee of the Chairman's Advisory Council dedicated ourselves to the task. We have spoken with members of the medical community, the legal community, and the claims community to determine what type of information would be most beneficial to the medical providers. As a result of those many communications, the committee met to create a manual that would assist medical providers in treating workers' compensation patients. This manual is the result of several group meetings and many hours of individual research. We have tried to set aside our own personal biases and interests to prepare a balanced look at the needs of a medical provider in Georgia's system. It is our hope that we have accomplished this goal. Each of the authors offers individual personal thanks to our respective office staff, particularly Cara Wallis and Karen Cox, for their many hours of merging and revising the submitted texts.

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## **DISCLAIMER**

The following materials were prepared by the Chairman's Workers' Compensation Advisory Council's Public Education Committee for the use of medical providers and their claims administrators in the general administration and handling of their workers' compensation patients. These materials have been prepared and made available to Georgia's medical providers who endeavor to assist employees who have been injured in a workers' compensation accident. The materials are intended to serve as a general overview of the Workers' Compensation Act so that medical providers will understand their role in the system. Please note that each employee's workers' compensation medical treatment is unique to that employee. Therefore, the general statements in this material may not apply to and may not be accurate in the context of each individual case.

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## **CHAPTER ONE**

### **I. INTRODUCTION**

In 1920, the Georgia General Assembly passed the Georgia Workers' Compensation Act (the "Act"). Historically, workers' compensation developed as a compromise between employers and employees to provide medical care and wage protection for the injured employee. Workers' compensation is a no-fault insurance system providing specific benefits to injured employees. Except for certain circumstances, it is irrelevant whether the injured employee was injured by accident, by carelessness, or by the intentional act of someone else. In return for providing a limited amount of benefits to injured employees, without regard to fault, employers were assured that they would not be subject to the liability of negligence law suits with the accompanying possibility of awards for pain and suffering, punitive damages, etc. This compromise, called "the exclusive remedy doctrine," still applies today.

The present workers' compensation laws provide for the employer to assume the cost of work-related injuries arising out of and in the course of their employee's employment without regard to fault. The employer is required to provide certain wage replacement benefits and medical benefits directly related to the injury, so long as the injury arose out of and in the course of the employment. Generally, an injury arises out of the employment if there is some causal connection between the injury and the employment activities. The injury is considered to be in the course of the employment if it occurred on the premises, during business hours, and when the employee was engaged in doing something incidental to benefit the employer. However, for certain conditions, such as cumulative trauma, aggravation of a pre-existing condition, stroke, hernias, heart attacks, hearing losses, unexplained deaths, and occupational diseases, there are often additional facts that must be presented for an employee to recover. Therefore, medical providers may be

asked to look at causal connection of the injury to assist the parties in determining if it is a workers' compensation injury.

If an injured employee is injured in a situation within the broad scope of the workers' compensation system, even if the case itself is deemed not to be compensable, the injured employee is prevented from suing the employer in tort. In most instances, the injured worker's only remedy is through the workers' compensation system, unless the injury is caused by the fault of a third party unrelated to the employer. If an independent third party is at fault, the employee may also be able to pursue a claim against that third party.

The State Board of Workers' Compensation (the "State Board") has jurisdiction in regard to workers' compensation or potential workers' compensation claims. The administrative law judges make the initial determination, when the issue is in question, as to whether an individual is an employee and then that administrative law judge determines if the accident arose out of and in the course of the employment. Once this determination is made, the employee could be entitled to one or all of three types of indemnity disability benefits available under the Act: *temporary total disability benefits(TTD)*, *temporary partial disability benefits(TPD)*, and *permanent partial disability benefits(PPD)*. Temporary total disability benefits provide compensation to an injured employee for total economic loss that he or she has undergone as a result of an injury. Temporary partial disability benefits compensate the employee for partial economic loss that results from the restrictions on his or her ability to work due to the on-the-job injury. Permanent partial disability benefits result when an injured employee has a permanent physical impairment and does not consider whether there has been any economic loss attributable to the injury. It is important to note that an

employee is only allowed to draw one of the three disability benefits listed above for any single accident at any single point in time.

Medical providers should be aware that, while an employer is responsible for medical treatment provided under a workers' compensation claim as a result of an injury at work, the employer is only responsible for the medical charges that have been incurred as a result of treatment by an authorized treating physician. Further, the employer only has to pay for those charges that are "usual, customary and reasonable" and that are "reasonably required" to "effect a cure, give relief, or restore the employee to suitable employment." O.C.G.A. §34-9-200 (a).

In the event there is a dispute as to the necessity of a certain type of medical service, the State Board has a procedure for a peer review process to determine whether the charges are appropriate under the existing medical fee schedule. When there is a question as to whether a medical service is "reasonably required," the State Board can review the differing medical opinions and also arrive at its own independent conclusion, thus disregarding all medical testimony submitted by the parties. Therefore, the administrative law judges at the State Board have a great deal of discretion to determine what medical treatment is reasonably required in a claim.

Medical providers should also remember that the employer is only responsible for those expenses which are "medical, surgical, and hospital care and other treatment, items, and services which are prescribed by a licensed physician, including medical and surgical supplies, artificial members, and prosthetic devices and aids damaged or destroyed in a compensable accident, which in the judgment of the State Board shall be reasonably required and appear likely to effect a cure, give relief, or restore the employee to suitable employment." O.C.G.A. §34-9-200.

As mentioned above, the State Board administers the Act. Under the Act, the Governor appoints the three board members, called directors, to a four-year term. The Governor also names one of these directors as the chairman of the overall agency. Under their direction, the Board's major responsibilities include: conducting hearings to determine if an injury is compensable and how much that individual will be paid in indemnity and medical benefits; setting procedural rules to govern functions and hearings before the Administrative Law Judges and the Appellate Division; monitoring claims for accuracy of payments for the duration of claims; conducting mediations to assist in disputes; and monitoring and determining if an employee has incurred a catastrophic injury which would require rehabilitation services. Additionally, effective July 1, 1995, the Board was given authority to prosecute and hear fraud cases. The Board may levy fines up to \$10,000.00 against employers, employees, insurers, and medical providers in the event a person, firm, or corporation willfully makes a false or misleading statement or representation for the purpose of obtaining or denying any benefit or payment under the Act.

## **CHAPTER TWO**

### **I. ESSENTIAL ELEMENTS OF A WORKERS' COMPENSATION CLAIM**

#### **A. WHO AND WHAT IS COVERED**

##### **1. EMPLOYEE/EMPLOYER**

Not all workers in the State of Georgia are covered by the state laws concerning workers' compensation. Employees of the U.S. government are exempt and are instead covered under the federal workers' compensation laws. O.C.G.A. §34-9-1(3) defines employer as a person or entity who has three or more persons regularly in service in Georgia. However, when an entity does not have the requisite number of employees, that entity may still be covered under the Act if the employees and the employer agree to be covered. Due to the broad scope of the definition, the term employer is largely defined by exclusion rather than inclusion. In this regard, several groups of employees are specifically excluded from the Georgia workers' compensation system, including railroad workers, domestic workers, and farm laborers. However, O.C.G.A. §34-9-3 specifically includes public employees, generally. Independent contractors (as opposed to employees) are not covered by workers' compensation. Employees working for an employer who employs less than three employees are not covered unless the immediate employer is a subcontractor working for a general contractor who employs three or more employees. It is sometimes difficult to determine whether a person working for another is an employee or an independent contractor. If the employer has the ability to control the time, method and manner of the performance of the work, then the person will generally be considered to be an employee rather than an independent contractor. Often in determining whether an employment relationship exists, it is helpful to ascertain the answers to three basic

questions: (1) Whether a contract for employment, written or verbal, exists between the alleged employer and employee; (2) Whether there is a payment or an expectation of a payment on the part of the alleged employee; and (3) A right of control exists by the alleged employer over the alleged employee. When each of these elements exists, an employment relationship exists. As with the determination of the employee status, it is the employee who bears the burden of proving that the employer has the requisite number of employees regularly in service in Georgia.

Once it is determined that the employment relationship exists and the employer is covered under the Act, the potential for entitlement to workers' compensation benefits is present, provided the injury is one that "arises out of" and "in the course of" employment. O.C.G.A. §34-9-1(4).

## **2. ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT**

In order for an employee to be entitled to workers' compensation benefits under the Act, the employee must suffer an "injury" as defined in O.C.G.A. §34-9-1(4). The term "injury" is defined as an accident "arising out of" and "in the course of the employment." The occurrence of either of these elements alone is insufficient. The accidental injury must have each element acting together, i.e., the accident must both arise out of and in the course of employment, before an injury is compensable

Georgia case law provides that an accident "arises out of" employment when there is a causal connection between the conditions under which the employee worked and the resulting injury. As a general rule, accidental injuries which occur and are deemed a risk directly associated with the employee's employment environment are compensable. On the other hand, those risks that are solely personal to the employee are usually not compensable.

The requirement that an injury by accident occurs “in the course of” employment is met when the accident occurs within the period of employment, at the place where the employee is reasonably expected to be in performance of his or her duties and while that employee is fulfilling those duties or is engaged in an activity incidental thereto. Activities that are intended to provide a direct or substantial benefit to the employer are considered to occur in the course of employment, regardless of whether said benefit actually occurs.

Even though workers’ compensation is commonly thought to cover “injury by accident,” occupational diseases, strokes, heart attacks, and cumulative trauma can also be covered. In order for these conditions to be covered, they must be causally related either to a traumatic injury on the job or to the job duties/conditions. Generally, the job duties do not need to be the sole causative factor, but the job duties must be a significant causal factor. Aggravation by one’s work activity of pre-existing conditions can also be covered by workers’ compensation, though the coverage is limited to the time period that the condition remains aggravated by the work. Workers' compensation medical providers are often asked to give opinions regarding whether a particular condition was caused or aggravated by the work duties. Though such determinations are often difficult for the medical provider, they are essential to the workers’ compensation system. All parties to a claim need the provider’s medical opinion as to causation so that the employer and employee know what is going to be covered under the Act and so the appropriate entity is billed for services rendered.

Certain psychological conditions can also be covered by workers’ compensation. However, in Georgia, psychological conditions must not only be caused or aggravated by the on-the-job injury or by the job conditions, but the conditions also must be associated with a physical injury on the job. A purely

psychological injury, without an associated physical injury or manifestation, is not covered under the current law.

### **3. CHANGE IN CONDITION/NEW INJURY**

The distinction between change in condition and new injury is a frequent source of litigation and creates one of the most common situations in which medical testimony is necessary. For this reason, it is important for medical providers to have an understanding of the distinctions between an initial injury, a change in condition, and a new injury.

The concept of initial injury is quite simple. An employee suffers an injury at work, is not known to have any previous injuries, and is in need of medical treatment. At that point, a medical provider is selected from the posted panel of physicians and medical treatment commences. Income benefits are commenced where the injury prevents the employee from working for more than 7 days.

The claim can become more complicated when a change in condition or new accident occurs. Both are distinct legal concepts. A change in condition occurs when an employee undergoes a change for the better, or for the worse, in his or her condition. A change in condition occurs only after there has been an original compensable injury. The employee must have received workers' compensation income benefits and medical benefits.

A change in condition claim can be brought by either party to a claim. The employee is likely to bring a claim after he or she has been released to return to work, or has actually returned to work, yet continues to experience problems related to the initial injury without the occurrence of a new injury. In that situation, the employee may attempt to have workers' compensation benefits reinstated. The employer/insurer are likely to claim a change in condition in a situation when an employee is capable of

working in some capacity, yet has not specifically returned to work. Confusion generally arises when an employee returns to work, continues to work over a period of time and then becomes unable to work. Things can also become complicated when an employer has changed insurance carriers or an employee has changed places of employment.

When an employee becomes unable to work, the question arises as to whether there should be liability for the original date of injury (a change in condition) or for the date that the employee becomes disabled again ( a new injury). While the distinction may not be significant to a medical provider, it is extremely significant to an injured worker. Among other things, if the employee was earning more at the time of the second occurrence, his or her compensation rate would be higher and he or she would be entitled to higher weekly benefits. If there have been different employers or different insurers, the date of injury applied determines the liability between successive employers and/or insurers. The distinction is also important when a statute of limitations problem exists and the second injury date is needed to keep the statute of limitations from barring the payment of benefits to the employee.

Ultimately, unless the parties agree, the determination of whether a disability is the result of a change in condition or a new injury is a question of fact for the administrative law judge. For purposes of medical management and, if necessary, medical testimony, the following questions can help determine whether the employee has undergone a change in condition or a new accident:

1. Did the employee return to work in the same position, then sustain a specific injury that caused the disability? In that situation, generally speaking, there is a new accident and the new date of injury would apply.

2. Did the employee's work, after returning from the initial injury, aggravate the pre-existing condition without a specific injury? Specifically, is the work environment new and different from the initial work environment? Are there "new circumstances" within the employment? If there are changes in the employee's work, then the new employer or insurer would generally be held liable.

3. Has the employee returned to work, continued in the same capacity with no change in employment or specific injury, but simply experienced "wear and tear" resulting from the original injury? In that situation, the initial date of injury would generally control.

#### **4. AGGRAVATION OF A PRE-EXISTING CONDITION**

Aggravation of a pre-existing condition is specifically included in the definition of injury under O.C.G.A. §34-9-1(4). Except as otherwise provided by the Act, the term injury includes "aggravation of a pre-existing condition by accident arising out of and in the course of employment, but only for so long as the aggravation of the pre-existing condition continues to be the cause of the disability; the pre-existing condition shall no longer meet the criteria when the aggravation ceases to be the cause of the disability." The aggravation of a pre-existing infirmity, congenital or employment related is compensable in Georgia.

When an employee sustains an on-the-job injury but, thereafter returns to work and ultimately ceases work due to the aggravation of the pre-existing condition through the performance of the post-injury work activities, the employee may be deemed to have sustained a "new accident" as of the date that performance of the job ceased. The administrative law judges will often balance the same factors detailed in the previously mentioned Change in Condition Versus New Accident section to determine whether an aggravation of a pre-existing condition and, therefore, a "new accident" has occurred. The "new accident"

theory of recovery was developed to escape claims being barred by the statute of limitations on a change of condition claim or initial injury. While this material is provided as a general outline of the claims, medical providers must understand there are legal questions controlled by very fact-specific instances.

## **B. INDEMNITY BENEFITS UNDER WORKERS' COMPENSATION**

### **1. AVERAGE WEEKLY WAGE/COMPENSATION RATE**

Under the Act, an injured employee is compensated at two-thirds of what he or she was earning pre-injury, with a maximum weekly cap that is set by the Georgia General Assembly. The average weekly wage, and corresponding compensation rate, can be determined through one of several methods. The preferred method is to look at the employee's thirteen weeks of earnings during the period immediately prior to the injury. Frequently, however, an employee may not have been employed for thirteen weeks. In such a situation, the wages of a similarly situated employee are used. In the event that neither of these two options is available, then the employee's full-time average weekly wage is used.

### **2. TYPES OF BENEFITS**

There are three basic benefits provided to an injured worker under the Act when he or she suffers an accident arising out of and in the course of employment; indemnity (income) benefits, medical benefits, and rehabilitation benefits. The following is a summary of these benefits.

#### **a. Indemnity Benefits**

Indemnity (income) benefits are designed to partially compensate a disabled employee for lost wages during the period he or she is incapable or limited in performing his or her work activities. There are three categories of indemnity benefits: Temporary total disability (TTD), O.C.G.A. §34-9-261; temporary

partial disability (TPD), O.C.G.A. §34-9-262; and permanent partial disability (PPD), O.C.G.A. §34-9-263.

1. Temporary Total Disability. An employee is entitled to temporary total disability benefits after a disability period of seven (7) days or more when the employee's disability is temporary in duration but total in character. Georgia's workers' compensation system utilizes an "earning impairment" theory approach with regard to TTD. This theory compensates an employee only for the difference between the pre-injury and post-injury wage. The term disability as used in this term solely focuses on the impairment of earning capacity as a consequence of the injury, and not on the physical disability. The disability must be authorized by the treating physician and can continue for a maximum period of 400 weeks, if the physician certifies that the employee is disabled as a result of an on-the-job injury. The date of disability is the first day that the employee is unable to work a full shift. For example, assume your patient sustained a work-related injury which required him to miss work for three weeks. His weekly salary was \$400.00 because he earned \$10.00 per hour and worked a 40-hour week. Indemnity benefits are for the three weeks he is out of work. Therefore, two-thirds of his average weekly wage is \$266.64, which is within the maximum of \$400.00 allowed by law.

2. Temporary Partial Disability. The employee is entitled to this benefit for a disability that is temporary in duration, but the disability is partial in character. Temporary partial disability benefits are paid when the employee returns to work, but suffers a loss in prior earnings either because he or she must work in a modified job for less wages or on a part-time rather than a full-time basis. As with TTD, TPD is based on the "earning impairment" theory rather than the "physical impairment" theory. Likewise, the term disability is utilized the same in TPD. Workers' compensation pays two-thirds of the difference between the

employee's average weekly wage before and after his injury, but no more than \$268.00 per week and no longer than 350 weeks from the date of the injury. The employee remains entitled to these weekly benefits as long as he or she is earning a lesser wage, whether with the same or a different employer. When the employee begins to earn the same or higher wage (or exceeds the 350 weeks), the entitlement to TPD ceases. For example, the employee in the earlier example returned to work, but the only suitable position paid \$5.00 per hour. The employee would then be earning one half of his pre-injury salary. Therefore, he would be entitled to two-thirds of the difference of his pre-injury wage (\$400.00) and his post-injury wage (\$200.00), which would be a \$133.20 payment per week for as long as his salary remained at \$200.00.

3. Permanent Partial Disability. The employee is entitled to these benefits for disability that is partial in character but permanent in quality resulting from the loss of or the loss of use of body members or from the partial loss of the use of the employee's body. PPD benefits are not due if the employee is entitled to TTD or TPD from the same accident. Unlike TTD and TPD, Georgia does not use the "earning impairment" theory with regard to PPD benefits; instead the "physical impairment" theory is utilized for PPD benefits. The "physical impairment" theory focuses solely on the injury to the employee's body, and not on the economic change in wages that may have occurred due to the injury. In short, PPD benefits are due regardless of economic loss. In addition, the term disability with regard to PPD does not focus on the change in an employee's wage, but strictly examines the degree of physical impairment to the body itself. The authorized treating physician gives the employee a permanent impairment rating pertaining to the loss of use of whatever part of the employee's body was injured in the accident pursuant to the American Medical Association's *Guide to The Evaluation of Permanent Impairment*, 5<sup>th</sup> Edition. A schedule of body

members is included in the Act, and this schedule sets forth the maximum number of weeks that an injured employee would be entitled based on the physicians' disability rating. O.C.G.A. §34-9-263.

For example, assume that an employee injures his right leg in a compensable on-the-job accident. He receives \$250.00 per week in temporary total disability benefits during the course of his disability. After the employee returns to work, his authorized treating physician assigns a 10% permanent impairment rating to the employee's right leg because the *Guide To The Evaluation of Permanent Impairment*, 5<sup>th</sup> Edition recognizes a percentage for permanent loss of use or range of motion, etc. This rating would entitle the employee to \$5,625.00 in permanent partial disability benefits.

b. Medical Benefits

The Act requires the employer/insurer to provide immediate medical, surgical, hospital, or other care as may be reasonably required to effect a cure, give relief, or return the employee to suitable employment. O.C.G.A. §34-9-200. In exchange for this immediate care, the Act allows the employer to choose the physicians from whom the employee seeks medical treatment. In order to retain this right, the employer is required by law to post a "panel of physicians" and the employee must seek medical care from a physician posted on this panel if medical treatment is to be covered under workers' compensation. As long as the employee obtains medical treatment from a panel physician and the condition treated is related to the on-the-job injury, workers' compensation will pay the medical expenses related to treatment by the authorized physician or the authorized referral physician.

c. Rehabilitation Benefits.

In certain instances, the employer/insurer are required to furnish the employee with vocational rehabilitation benefits reasonably required to restore him or her to suitable employment. The parties can agree to provide these benefits or the employer/insurer are required to provide them when an injury is deemed catastrophic. Rehabilitation services are to be provided by an appropriately certified supplier. This supplier outlines a formal written rehabilitation plan specifying services needed, time factors, costs, and overall objectives. Board Rule 200.1. Communication among all parties, including the medical provider, is essential to a successful rehabilitation plan. Rehabilitation benefits are discussed more fully in Chapter Seven.

### **C. CATASTROPHIC INJURY**

Georgia workers' compensation law specifically sets out a category of injuries that are designated as "catastrophic injuries". These injuries are codified at O.C.G.A. §34-9-200.1.

A catastrophic injury is defined as any injury that is one of the following:

1. Spinal cord injury involving severe paralysis of an arm, a leg or the trunk;
2. Amputation of an arm, hand, foot or a leg involving the effective loss of use of that appendage;
3. Severe brain or closed head injury as evidenced by:
  - A. Severe sensory or motor disturbances;
  - B. Severe communication disturbances;
  - C. Severe complex integrated disturbances of cerebral function;
  - D. Severe disturbances of consciousness;
  - E. Severe episodic neurological disorders;

- F. Other disturbances at least as severe in nature as any condition listed above.
4. Second or third degree burns over 25 percent of the body as a whole or third degree burns over 5 percent or more of the face or hands.
  5. Total or industrial blindness;
  6. Any other injury of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy for which such employee is otherwise qualified. The affirmance or denial of an employee's social security application is admissible in evidence under this subsection, but is not controlling on the award from the administrative law judge.

When an injury becomes catastrophic, there are many issues that directly impact medical providers. A major issue is the provision requiring the appointment of a catastrophic rehabilitation supplier for the employee. The rehabilitation supplier's responsibilities include medical management and, when necessary, vocational rehabilitation. Medical management can include visits with the employee to a physician's office to assist both the employee in understanding his or her medical problems and the third party payer in fulfilling its obligations to the employee. It can also include home modifications when needed, and transportation for employees who may be unable to drive or who may not have suitable transportation available. The catastrophic rehabilitation supplier is required to regularly document the employee's medical condition and vocational prognosis through a rehabilitation plan that must be submitted to the State Board.

Medical providers treating a catastrophically injured employee often function as part of an overall treatment team and are sometimes encouraged and/or expected to participate in meetings with the parties to

a claim. Additionally, medical providers who become involved in catastrophic claims are often specialists who do not normally work within the workers' compensation system.

## **CHAPTER THREE**

### **I. ESSENTIAL ELEMENTS OF CLAIMS HANDLING**

An employer's workers' compensation claims professional is very important because he or she will ultimately initiate the payment of a claim and, thus, communication with the medical provider may be necessary. The workers' compensation claims professional has four major responsibilities: (1) the thorough investigation and management of all aspects of each workers' compensation claim; (2) the accumulation, analysis, and management of all costs related to all medical reports, medical providers fees, hospital fees, funeral expenses, rehabilitation expenses, and other associated costs related to each claim; (3) the processing of workers' compensation checks to employees who qualify for income benefits; and (4) the processing of payment of authorized workers' compensation related medical bills in accordance with the current medical fee schedule.

#### **A. INITIATING A CLAIM**

The entire claims handling process originates with the Employer's First Report of Injury (form WC-1), which is prepared by the employer and forwarded with all known facts pertaining to the injury directly to the insurer immediately after the employer is made aware of the injury. The first date the employer is aware of the injury is not always the same as the injury date. An injured employee may not inform his or her employer of an alleged injury until days or even weeks after the alleged accident. Under the Act, the employee has 30 days to report his or her on-the-job injury to the employer.

The employer has 21 days from the date of the employer's knowledge of the injury to controvert a claim or accept a claim and make payment of benefits due. The employer's failure to properly report an injury on the WC-1 First Report of Injury causes a delay in the entire system and often results in hardships for the employee and the insurer. The State Board has the authority to assess penalties and attorney's fees, if the employee is represented by an attorney, against the employer/insurer if the claim is not properly denied or paid within the requisite 21 days. Obviously, the claims professional cannot deny or pay the claim until he or she is made aware of the injury through the Employer's First Report of Injury (WC-1). Thus, immediately after the employer is made aware of the accident, the employer should complete section A of the First Report of Injury and send it to the insurer.

Another important form to be completed by the employer during the initial stage of the claim is the Wage Statement Form (WC-6), which provides the average weekly wage of the employee for the 13 weeks preceding the date of accident. The insurer will use this to calculate the average weekly wage and will then file a Wage Statement with the State Board. This information can now also be provided to the State Board by completing the back side of the WC-1 form.

## **B. COMMUNICATION**

Communication of medical opinions is one of the most important issues in caring for workers' compensation patients, second only to quality medical care. Decisions that are made by the authorized treating physician as to diagnosis, treatment, and work status, as well as issues of causality, have economic implications for all parties and must be communicated in a timely manner. A designated staff person can be

key in communicating with the employer, claims professional, etc. so as to assist in the transmittal of necessary timely medical opinions.

Typewritten medical records are preferable to handwritten, especially since these documents are frequently utilized by multiple parties and are used to resolve legal issues. Notes should be dictated and transcribed as quickly as possible, reviewed, and then faxed or mailed to the appropriate parties. In workers' compensation claims, the medical records are open to all legitimate parties to the claim, including the claims professional, employer, employee, employee's attorney, defense attorney, and authorized case manager.

Telephone calls between the parties can be helpful in resolving difficult issues or explaining the course of treatment. The claims professional frequently does not have the medical background to understand the complexities of medical treatment and needs clarification from the medical provider or his or her staff. Some claims professionals have e-mail addresses as well as telephone extensions and a fax number which they have available for messages of medical clarification.

## **1. THE IMPORTANCE OF MEDICAL RECORDS**

Medical providers new to workers' compensation do not realize how important medical reports are to the handling of a claim as all parties need this information to make most decisions on medical treatment and employment activities. Information regarding whether the cause of the injury or condition is related to the job is needed so that the employer/insurer can determine if the condition should be covered by workers' compensation. Diagnosis, prognosis, and treatment plans are needed so that decisions can be made about

properly handling legal issues in cases. Work restrictions are needed because that determines the injured worker's entitlement to weekly income benefits.

Many times the origin of an injury or condition is unclear and, in such cases, parties often compare the testimony of the injured employee to the history taken by the medical providers shortly after the injury. Therefore, it is essential that the authorized treating physician carefully record the history of the injury or condition given by the employee. It is also important that the medical provider list all physical complaints and not just the primary complaint, since there are frequent disputes regarding the compensability of secondary diagnoses.

If the authorized medical provider includes all of the relevant information in the office notes, the parties and the attorneys will be much less likely to contact that medical provider with requests for additional information. If the authorized medical provider does not keep detailed and legible notes or does not include all of the necessary information, then the parties and the attorneys will have little or no choice but to request additional written information and sometimes depositions.

The medical fee schedule issued by the State Board provides for a fee of .50 per page with a \$10.00 minimum charge for copies of medical records. Additional fees such as "retrieval fees" and "documents fees" are prohibited. However, office notes and supporting documentation are required when submitting your bill to the employer/insurer for payment and charging for the medical report itself is not allowed.

By statute, the employer/insurer have the right to obtain copies of the medical records of the injured worker without obtaining a release for the records. However, this right is not absolute and does not supersede certain statutes guaranteeing confidentiality of certain types of medical information, such as HIV

information. In order to assist the employer/insurer in promptly obtaining proper information, injured workers are required to provide a signed release for medical information to the employer/insurer upon request. If the employee refuses to provide a signed release, any weekly income benefits being received by the employee can be suspended until such time as the signed release is provided. Medical records can also be requested by formal legal service of a Request for Production of Documents by one or more of the parties.

### **C. CONTROVERTING CLAIMS OR MEDICAL TREATMENT**

Often a claims professional may determine that medical treatment is not related to the workers' compensation claim. He or she is then required to "controvert" that proposed treatment.. Generally, a "controverted" claim is a claim that has either been denied in full or in part. Georgia law requires that an employer/insurer investigate and either accept or deny a workers' compensation claim within 21 days. If the claim is accepted, filings are made, medical treatment is approved, and when necessary, benefits are commenced. If the claim is denied, a filing is made that specifically denies the claim.

Additionally, a "controvert" or denial often occurs during the course of medical treatment when a question arises as to whether the medical treatment being offered is related to the compensable injury, or whether the treatment is reasonable or necessary. For example, an employee may sustain a back injury that requires surgery. The employee may suffer diabetes, high blood pressure or some other pre-existing and unrelated medical condition that could complicate the surgical procedure and that certainly requires separate medical treatment. The employer/insurer may deny any medical treatment related to the diabetes or high blood pressure as unrelated to the compensable injury.

A controvert also frequently is filed when an employee experiences an initial injury to one part of the body, yet then experiences or complains of symptoms elsewhere. For example, the patient who injures a knee and then begins limping can sustain damage to a hip or a back. It is not uncommon for an employer/insurer to controvert such complications as being unrelated to the original injury. The claims professional could deny treatment until such time as the employee goes before an administrative law judge for determination of the treatment's relationship to the compensable injury.

#### **D. MEDIATION OF MEDICAL DISPUTES**

Certain types of disputes are routinely referred for mediation prior to the scheduling of a hearing before an administrative law judge. These disputes can include requests for change of authorized treating physicians, determinations of whether certain treatment is authorized, and disputes regarding unpaid medical bills. Mediations take place at various locations throughout the state with the assistance of a mediator from the State Board.

Mediation is essentially a structured negotiation between the parties. It is an informal procedure during which the parties attempt to negotiate a resolution of the issues in dispute with the assistance of the State Board mediator. There is no judge present, and there is no "ruling" by anyone from the State Board as a result of the mediation. Mediations generally are quicker and less costly than hearings. The State Board has experienced a very high success rate resolving issues as a result of mediations.

However some issues do not lend themselves well to mediation. These issues will be scheduled for a hearing before an administrative law judge without first going through mediation. Also, those matters not resolved at a mediation will be scheduled for a hearing before an administrative law judge.

## **CHAPTER FOUR**

### **I. MEDICAL TREATMENT UNDER THE ACT**

As mentioned in the Introduction, the employer is obligated to provide and pay for medical treatment in accordance with O.C.G.A. §34-9-200, but it has a right to provide the name of physicians who are available to provide that medical treatment. Therefore, the employer must post a panel of authorized physicians in a prominent place or places on the business premises. In addition to this requirement, the employer must take “all reasonable measures” to ensure that the employees understand the function of the posted panel and their right of selection from this panel, and that the employees are given appropriate assistance in contacting a panel physician if necessary. O.C.G.A. §34-9-201. These requirements are key if the employer wishes to have the employee seek medical treatment from a panel physician and have the bills paid under workers’ compensation. If the employer fails to post the panel of physicians, explain the purpose of the panel of physicians, or assist the employee in choosing a physician, then the employee can seek treatment from any physician. The employee is not limited to those physicians named on the posted panel; instead a medical provider selected by the employee becomes the authorized treating physician and, thereafter, the employee follows the same rules regarding a change of a physician as those provided for a change of physician when the posted panel is utilized. Also, if the employee wishes to seek medical treatment from a provider who is not on a properly posted and explained panel, he or she may do so, but the medical bills may not be paid by the employer/insurer and may be challenged by the group health provider.

## **A. THE PANEL OF PHYSICIANS**

### **1. THE TRADITIONAL POSTED PANEL OF PHYSICIANS**

The posted panel of physicians should be the starting point for medical treatment of injured workers. There are now three types of panels that an employer can post for work-related injuries. The traditional panel under O.C.G.A. §34-9-201(b)(1) is a list which should include at least four non-affiliated physicians, professional associations, or corporations of doctors who are reasonably accessible to the company's employees. At least one of the doctors must be an orthopedic surgeon. Not more than two industrial clinics can be included on the panel. If possible, the list should also include a minority physician. Effective January 1, 2002, the panel must include at least six independent medical providers.

Assuming that the injured worker is treating with an authorized physician and is dissatisfied with the treatment, he or she has the right to change from one physician on the panel to another panel physician without prior approval from the employer/insurer or the State Board. This rule applies to the traditional panel, the conformed panel and the WC/MCO.

If the injured worker does not wish to change to another physician on the panel, he or she can attempt to change to a non-panel physician of his or her choice. This can be accomplished in several different ways. The easiest method is simply for the parties to agree for a change to another physician. One of the parties should file a Form WC-200(a) with the State Board identifying the new treating physician with the effective date of the change. If the parties cannot agree on a change of physician, either party may file a request for change of physician with the State Board using Form WC-200(b). Supporting documentation must be attached in the form of admissible evidence, such as medical records and affidavits, outlining why that party asserts that a change of physician is necessary. The opposing party has fifteen days within which

to file an objection to the request. After the fifteen day period, an administrative law judge will issue a written decision either granting or denying the request or refer the matter to mediation.

## **2. THE CONFORMED PANEL OF PHYSICIANS**

In addition to the traditional panel, the employer may utilize a Conformed Panel of Physicians. This is a larger panel that generally consists of at least ten physicians or professional associations, including general surgeons and chiropractors, and at least one minority physician. The “Conformed Panel” works similarly to the traditional panel in that once an employee makes a selection from the panel, the employee can elect to make only one change to another physician on the panel without approval of the employer/insurer or prior authorization from the Board.

## **3. THE WC/MCO**

In 1994 the Georgia General Assembly enacted legislation that allows employers the option of offering a managed care organization to their employees for purposes of providing medical care for job related injuries and illnesses. An employer/insurer may contract with a managed care organization (“WC/MCO”) certified under O.C.G.A. §34-9-208 for medical services. The State Board certifies organizations that demonstrate they meet established criteria. Currently there are twenty-two (22) organizations certified in Georgia to provide managed care programs in workers’ compensation.

Features of a certified WC/MCO include:

Employee chooses a physician from a network of providers rather than a panel of physicians;

Physician has predictable reimbursement based on the contract with the WC/MCO;

Physician has consistent procedures for pre-certification based on the contract with the WC/MCO;

Physician can communicate with the WC/MCO nurse case manager as provided by Board rule;

WC/MCO's have internal dispute resolution procedures;

WC/MCO's have internal peer review programs;

Improved communication and control;

Offers a network of geographically accessible specialists for referral;

Offers financial incentives for appropriate utilization of services; and

Promotes early return to work.

Notice must be given to the employees of the eligible medical service providers along with information regarding how to receive medical services under the WC/MCO. All reasonable measures must be taken by the employer to see that employees understand the function of the WC/MCO panel, have the right to select a physician from the panel after sustaining a work-related injury, and are given appropriate assistance in contacting panel or WC/MCO members when necessary. Medical providers that are a part of a WC/MCO must review that MCO's policies and procedures manual.

## **B. FREQUENT ISSUES ENCOUNTERED BY MEDICAL PROVIDERS**

### **1. MODIFIED DUTY WORK**

It is undisputed that the sooner an employee can be returned to the workplace following an injury, the better it is for all parties involved. In most scenarios, a medical provider will generally recommend "modified duty" restrictions. These restrictions should have a time frame and the medical provider should be

as specific as possible as to the limitations. The patient should be re-evaluated frequently while under restrictions until maximum medical improvement (MMI) is reached and permanent restrictions should be labeled as such.

When making the determination about an employee's disability status, the medical provider should assess the employer's ability to provide modified or transitional work. The modified work should be "meaningful" to insure a successful return. One of the most common avenues to return an injured employee to work is through a Form WC-240. When this procedure is utilized, an employee is offered modified duty work and given an opportunity to perform the modified duty. The Act provides a "grace period" of 15 working days to see if the return to work attempt is successful. If it is not, the employee would be immediately reinstated with weekly income benefits. This is very reassuring to the employee who is not sure if he or she will be able to successfully return to a modified duty job.

In order to return an employee to work utilizing this Board procedure, the employer/insurer must provide the authorized treating physician with a copy of a job description and/or job analysis that includes:

1. A description of the essential job that is to be performed.
2. The hours to be worked.
3. The rate of pay.
4. A description of the essential tasks to be performed. The job description must be specifically approved by the authorized treating physician, as without approval from the authorized treating physician, the form is invalid.

Functional capacity evaluations "FCE" can be used to determine with some objectivity the employee's job limitations, but are most helpful when the medical condition has stabilized and are helpful

when a specific job is being considered. FCE's can often help to sort out issues of validity, psychogenic overlay, etc.

The use of a Work Status Form when modified duty is appropriate is highly recommended and the form should be completed at every medical examination. The form should include the patient's name, the date, the diagnosis, any restrictions, and the date of the next follow-up if one is scheduled. It is helpful to summarize the treatment plan as well. These forms, when provided to all parties within a short period of time, act as a valuable piece of information pending receipt of the formal office note.

Review of detailed job descriptions, videotapes, and site visits are occasionally required to resolve difficult return-to-work issues, especially in cases where litigation is ongoing. Billing for the extra time required is proper and codes listed in the medical fee schedule should be used.

Returning a patient to work who has not been released to full duty creates some of the most frequent litigation in the workers' compensation system. As with other topics discussed elsewhere in this manual, it is also one of the areas in which a medical provider is most frequently required to offer medical testimony.

## **2. DRUG TESTING**

In 1993, the Georgia General Assembly created the "Drug Free Workplace Program." Under this legislation, an employer who establishes and maintains a drug-free workplace is entitled to a reduction in its workers' compensation premiums. As a consequence of the drug-free workplace legislation, in conjunction with Georgia law governing drug use and job injuries, drug testing has become more prevalent in workers' compensation claims.

Drug testing is often used on a pre-employment basis. Additionally, many companies have policies that require drug testing in the event of a job injury. The drug testing is necessary not only to protect the “drug free workplace” designation, but also to determine whether a claim should be controverted. After a job injury, if an employee tests positive for alcohol and/or drug abuse within a specific time frame, the entire claim can be denied.

Most employers have designated labs that are used for post-injury drug testing. Medical providers need to be aware of the results of a drug test for several reasons. The most obvious one is to assist in prescribing medication when the possibility of abuse exists. Additionally, when a positive drug and/or alcohol test has occurred, the medical provider should be aware that, in all likelihood, the claim may be controverted and medical treatment will not be paid until a judicial decision is made or an agreement is reached between the parties.

### **3. REFERRALS BY AUTHORIZED TREATING PHYSICIAN**

Once the employee chooses a physician from a properly posted panel, that physician becomes the “authorized treating physician.” The authorized treating physician is allowed to refer an injured worker to another provider for specialized treatment so long as the first authorized treating physician continues to remain the primary treating physician. If the first authorized treating physician does not intend to continue treatment, then the parties must arrange for a change of authorized treating physician either by agreement or by Order of the State Board.

If a referral for specialized care is properly made by an authorized treating physician (and that physician does remain the primary physician), the new physician to whom the injured worker is referred is

not allowed to make additional referrals. Instead, the second physician must refer the injured worker back to the first authorized treating physician for any additional referrals.

#### **4. EMERGENCY MEDICAL TREATMENT**

An injured worker is authorized to seek treatment with any appropriate medical provider such as a hospital emergency room if a situation exists requiring emergency treatment. However, once the emergency situation has passed, the injured worker is required to follow the usual procedures to obtain treatment with the authorized treating physician. After the emergency has passed, the provider of the emergency treatment will no longer be deemed authorized.

#### **5. INDEPENDENT MEDICAL EVALUATIONS**

One time only in a claim, an injured employee has the right to an independent medical evaluation (“IME”) by a medical provider of his or her choice within 120 days of receipt of income benefits. The injured worker can be examined in the State of Georgia or within 50 miles of his or her residence at a reasonable time and place. The employer/insurer must be notified in writing in advance of the appointment. The employee scheduling the IME can request a physical examination, a psychiatric evaluation, a psychological evaluation, or an FCE. The employer/insurer will be required to pay for the visit subject to a limitation of \$250.00 for repeat diagnostic testing. However, please note that if the injured employee is able to pay for an evaluation by other means, he or she can schedule as many IME’s as he or she desires.

The employer/insurer also has the right to send the employee to IME's. O.C.G.A. §34-9-202(a) allows the employer, at any time, to order the injured worker to submit to an examination at a reasonable time or place by a qualified physician designated by the employer/insurer. Under Board Rule 202, the employer must give ten days written notice of the time and place of the examination, and advance payment of travel expenses must accompany the notice. The employer/insurer are not permitted to suspend weekly benefits for the employee's refusal to submit to an IME.

## **6. FUNCTIONAL CAPACITY EVALUATIONS**

One of the most common forms of testing, post-injury and post-medical treatment, is the FCE. An FCE can be requested by virtually any party to a workers' compensation claim. It is important that the vendor for the FCE provide enough validity criteria to validate the FCE.

The evaluation, when properly performed by both the employee and the medical facility, provides a tremendous amount of information that is used by all parties. For a medical provider, it helps determine just what limitations an employee might face when released to return to work. It can also provide guidance for the assignment of a permanent disability rating. For an employer, it can help in determining what work place modifications can be made for re-employment or what other positions in the work place might be appropriate. For the rehabilitation supplier in a catastrophic claim, it can help determine what modifications might be necessary to a home, what limitations a patient may have that might render him or her completely unemployable, or that might be used to provide job place modifications.

## **7. REFUSAL TO ACCEPT MEDICAL TREATMENT**

In instances where an injured worker, without reasonable cause, refuses to accept medical treatment when ordered by the State Board, the State Board has the discretion to suspend or reduce compensation to the employee, unless it determines that such refusal was justified. Although O.C.G.A. §34-9-200(c) also refers to “surgical care,” an employee is not required to undergo surgery, nor is he or she required to submit to invasive testing, such as a myelogram, in order to continue to receive benefits.

## **8. APPROVAL FOR DIAGNOSTIC TESTING**

Frequently, a medical provider may wish to verify or further treat an injury through different types of diagnostic testing. As a general rule, the employer/insurer are required to approve any medical treatment that helps effect a cure, give relief or restore the employee to suitable employment. This includes testing which is necessary to establish causation of the medical condition. Practically speaking, when a medical provider is the primary authorized treating physician, any diagnostic testing or other treatment recommended by the provider is authorized if it is causally related to the claim or necessary to establish causation. Recent changes in Georgia law now require an employer/insurer to either authorize or deny a request for diagnostic testing within five days if a written request has been properly submitted on the correct Form WC-205. If the diagnostic testing is being requested by a referral physician, the requirement of approval is not quite as clear, but frequently, if the primary physician believes it is necessary, the diagnostic testing may be approved.

## **9. PRE-AUTHORIZATION IN WORKERS' COMPENSATION**

The Act does not require an authorized provider to obtain pre-authorization except in circumstances where treatment is being provided by a Board certified MCO. However, it has become customary for medical providers to obtain “pre-authorization” for medical treatment/tests. In recent years, this custom produced serious problems in workers’ compensation, as there is nothing in the Act which requires an employer/insurer to provide pre-authorization for any treatment/test within any given time frame. Thus, a delay in treatment could result if there was no authorization.

The State Board recently amended Board Rule 205 and issued a new Form WC-205. The Rule requires a response from the claims professional, within five business days, to a request for authorization for treatment or testing by an authorized treating physician. The new form is designed to be sent by an authorized treating physician by either fax or e-mail to a claims professional to request authorization for treatment or testing. The authorized treating physician must certify on the form the date and method of transmission. If completed properly by the authorized treating physician, the claims professional must respond within five business days or the request for treatment is deemed approved. Upon receipt of the properly completed form, the claims professional can either approve the request, deny the request, or ask for clarification and provide guidance as to what clarification is necessary. When replying, the claims professional must certify the date of response and whether that response is by fax or by e-mail.

## **CHAPTER FIVE**

### **I. BILLING OF MEDICAL EXPENSES**

Generally, the employer/insurer pay for medical expenses as a result of a bill being submitted by the medical provider. A medical provider may not file a workers' compensation claim on his or her own behalf in order to obtain payment for treatment of a workers' compensation patient. However, the medical provider can become a "party at interest" so that he or she may seek to enforce a judgment against the employer/insurer. O.C.G.A. §34-9-206. However, the employer/insurer must have an obligation to pay that medical provider before the medical provider can avail himself or herself of O.C.G.A. §34-9-206. Therefore, a medical provider's right to recover for services rendered is a derivative of a right arising from a compensable claim filed by the employee. It is imperative for medical providers to understand that under the Act, they cannot bill an employee directly for treatment provided in a workers' compensation claim. The Act specifically prohibits such billing. O.C.G.A. §34-9-205(b). Therefore, it is the medical provider's duty to bill the correct employer/insurer responsible for payment of that treatment.

Additionally, the medical provider must utilize the appropriate format for billing. The Act specifically states that "no physician, hospital, or other provider of services shall be entitled to collect any fee unless reports required by the State Board of Workers' Compensation have been made." O.C.G.A. §34-9-205(a). Currently, the medical provider must submit a properly completed WC-20, UB92, HCFA 1500, or HCFC 1450, with supporting narrative. Without this documentation, the responsible party is not required to issue payment. Therefore, the medical provider must utilize the appropriate forms and also provide the necessary supporting narrative. It is only after the employer/insurer have received a properly

submitted bill and supporting documentation that the period of time within which the payor is required to pay or contest a bill begins to run under O.C.C.G.A. 34-9-205(a) and Board Rule 205(a).

#### **A. BILLING PER THE FEE SCHEDULE/PEER REVIEW**

A medical fee schedule exists to establish maximum fee amounts and uniform payment guidelines for reimbursing medical providers for the treatment of injured employees subject to the authority of the State Board. The fee amounts included represent usual, customary, and reasonable reimbursement amounts for the specific services rendered. If a medical provider is treating a patient in a workers' compensation claim, it is imperative that he or she obtain and utilize the most current copy of the Workers' Compensation Medical Fee Schedule for Services Provided Under the Georgia Workers' Compensation Law (the "fee schedule"). The rules of the fee schedule shall be used by employers, insurance carriers, self-insurers and other payors for purposes of approving and reimbursing medical charges submitted by physicians or other medical providers for services performed in the treatment of work-related injuries or illnesses.

The fee schedule includes fee amounts for specific medical services and procedures as identified using "CPT" numeric identifying codes and modifiers for reporting medical services and procedures as established by the *Physician's Current Procedural Terminology* (CPT-4), 2001 edition, copyright by the American Medical Association (AMA). Any use or interpretation of CPT-4 service descriptions not specifically described in the fee schedule shall be based on the *Physician's Current Procedural Terminology* (CPT-4), 2001 edition.

It is important to note that the State Board reserves the authority to determine the applicability of all rules of the fee schedule. Any physician, other medical professional, or other entity having questions

regarding the applicability of the fee schedule to their individual reimbursement should direct any such question to the Directors or Executive Director of the State Board.

The fee schedule does not list each and every possible medical or health care providers' service. Board Rule 203(a) deals with certain charges that are not contained within the fee schedule. In such instance, the employer is simply required to make payment of that invoice if the charge is "reasonable, usual, and customary." If those charges are not contained in the fee schedule and are disputed as not being usual, customary and reasonable, the employer/insurer, or medical provider must file a request for peer review with a State Board approved peer review organization within 30 days of receipt of the charges and serve a copy of this request and any supporting documentation upon all parties and their attorneys. Board Rule 203(b)(2). The State Board approved peer review organizations are Disability Solutions, Inc., Georgia Psychological Association, Georgia Chiropractic Association, Appropriate Utilization Group, LLC, or such organizations as the State Board has posted as designated to do so. There are certain technical requirements necessary when submitting a dispute to a peer review organization. Therefore, the medical provider should obtain a copy of Board Rule 203 and follow the procedure outlined therein if requesting peer review of a medical bill.

If there is no appropriate peer review organization, the party requesting review may request a mediation conference by filing a form WC- 14 with the Board. The charges submitted which conform to the fee schedule shall be prima facia proof of the usual, customary, and reasonable charges for the medical services provided.

Within 30 days from the date the peer review organization issues a decision, the employer/insurer shall make payment of disputed charges based upon the peer review recommendations, or request a

mediation conference or an evidentiary hearing. A medical provider 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 recommendation of the peer review organization shall be evidence of the usual, customary, and reasonable charges. In cases where the peer review organization recommends that the fee be reduced, the employer/insurer shall pay the medical provider the fee amount recommended less the filing cost initially paid by the employer/insurer. In the event the peer review organization recommends that the entire fee be disallowed, the employer/insurer may automatically deduct the filing cost for the peer review from further allowable expenses submitted by the medical provider.

## **B. PAYMENT OF MEDICAL BILLS**

Of course, medical providers are to be paid for services rendered. But in order to be paid under the Act, the medical provider should obtain a copy of the fee schedule from the State Board and prepare bills in compliance with the allowable charges. Remember, the employer/insurer are not required to make payment of the bill unless the bill is submitted on an approved form with the appropriate supporting documentation. Unfortunately, timely payment is not always made. Sometimes the employer/insurer must question the amount of the bill, must question the medical necessity for the treatment, or must question the causal connection of the treatment. The payor may also refer the bill for peer review.

The complexities of the workers' compensation law can be frustrating to the medical provider who has provided treatment but not received payment. In many cases, payment is routinely made. However, where there is a dispute in a case concerning payment of medical bills, it is not proper to try to shorten the

process by seeking collection of the fees from the injured worker. Remember the workers' compensation law provides that during the time that a dispute is pending concerning the employer/insurer's responsibility for the payment of the bills, the medical provider is prohibited from attempting to collect payment from the injured worker.

Under the Act as amended on July 1, 2001, the employer/insurer must pay reasonable and necessary medical charges, subject to the fee schedule, within 30 days of receipt of the charges and required reports which are submitted by an authorized provider. The Act provides for a 10% penalty if charges remain unpaid after 30 days but are paid within 60 days of the submission, and an additional 10% penalty if the charges are not paid until after 60 days. If properly submitted charges remain unpaid after 90 days, interest will accrue on the combined sum of the charges and penalties at the rate of 12% per annum beginning on the 91<sup>st</sup> day. The penalties and interest are payable directly to the provider.

The State Board has created a new position to assist medical providers and payors with payment issues. The current medical claims coordinator is Tonya Wilson who can be reached at (404) 463-0563 or [WILSONT@SBWC.STATE.GA.US](mailto:WILSONT@SBWC.STATE.GA.US).

## **CHAPTER SIX**

### **I. LITIGATION PROCEDURE**

#### **A. HEARINGS/APPEALS**

An evidentiary hearing is conducted following the same rules of civil procedure and the same rules of evidence that are used in the Superior Courts and State Courts of Georgia. Testimony is given, objections are made, and briefs are usually submitted afterward. Discovery procedures such as depositions, interrogatories, etc., are also available to each party prior to the hearing. Medical records that are used as evidence at the hearing must be exchanged by the parties at least ten days prior to the hearing.

The decision from the administrative law judge will usually be made in writing after the hearing. There is no jury because the administrative law judge is the sole finder of fact. The written decision or “Award” will be mailed by the administrative law judge to all parties of record in the case.

If any party-at-interest is dissatisfied with the decision of the administrative law judge, that party may file an appeal within twenty days. The appeal will then be heard by the Appellate Division. The Appellate Division consists of the Chairman of the State Board as well as the two Directors. The appeal may be submitted by briefs alone or may include oral argument before the Appellate Division. Oral argument before the Appellate Division is conducted only if the appeal specifically requests oral argument. The Appellate Division issues a decision in writing after the briefs have been submitted and after the oral argument, if requested, has been conducted.

If any party-at-interest is dissatisfied with the decision of the Appellate Division of the State Board, that party may go outside of the workers’ compensation system by appealing to the Superior Court of the

county where the injury occurred. There are strict time requirements and procedural requirements that make appeals to the Superior Court somewhat technical.

The majority of litigated cases do not go beyond the Appellate Division of the State Board. The appeal to the Superior Court is the last appeal to which any party has a right in a workers' compensation claim. Appeals to the Georgia Court of Appeals and the Supreme Court of Georgia are discretionary with these courts. This means that the party must request permission from these courts to hear further appeals. Discretionary appeals are granted occasionally by the Court of Appeals and on rare occasion by the Supreme Court. Many times the parties will agree upon a resolution of the issue or an overall settlement of the claim at mediation or after the decision is issued by the administrative law Judge.

## **B. SUBPOENAS**

In a workers' compensation claim, witnesses are compelled to appear to testify if they are served with a State Board subpoena. Subpoenas are signed by the directors of the State Board, but are issued by the attorneys for the parties. These subpoenas can be served on anyone in the State of Georgia, and require the person upon whom they are served to be present and give testimony at a time and place indicated on the subpoena. In Georgia, the subpoena may require the person to attend a hearing before an administrative law judge or to attend a deposition. The subpoena may also require the person being subpoenaed to bring documents or other items to the hearing or deposition.

The subpoena is normally delivered by certified mail, return receipt requested in order to prove delivery of service. When a party utilizes the subpoena power, a copy of the subpoena to attend a hearing should be sent to the administrative law judge. The subpoena requires the individual named therein to attend

the hearing or deposition and provide expert medical testimony. The subpoena is an Order of the State Board and may be enforced by the judicial power of contempt.

### **C. EXPERT DEPOSITION TESTIMONY**

Testimony at a hearing can also be provided by deposition. The person being deposed is called the deponent. Normally, testimony of an expert witness, such as a medical provider, is tendered in a case by the taking of a deposition in lieu of the medical provider's live testimony at a hearing. This deposition is normally scheduled by finding a mutually agreeable time and date for the medical provider and the lawyers. The deposition of a medical provider is usually, but not always, taken at the provider's office. The deponent is placed under oath, all parties to the case are allowed to be present and ask questions, and a court reporter is present to transcribe all of the questions and answers.

After the deposition, the court reporter prepares a typed transcript of the proceeding. Following the preparation of the transcript, the deponent has the right to read the transcript, make any corrections of any answers taken down incorrectly by the court reporter, and then sign the deposition, verifying its accuracy. The deponent may also elect to waive the formality of reviewing the deposition for accuracy. In workers' compensation claims, the medical providers often choose to waive signature to avoid the delay in reviewing the testimony.

A deposition is taken as an accommodation to the medical provider's busy schedule. The medical provider should cooperate with the scheduling of a deposition because without a deposition, the lawyer may have no choice but to serve the provider with a subpoena to attend the hearing before an administrative law judge. The taking of the deposition in the provider's office infringes much less on the provider's time than it

would take if he or she were to attend the hearing before the administrative law judge and wait his or her turn to testify in person.

The fee schedule limits the fee for medical deposition testimony. Currently, the fee schedule limit is \$300.00 for the first hour or parts thereof and \$75.00 for each additional 15 minutes.

#### **D. MEDICAL RECORDS AS EVIDENCE**

The receipt and review of medical records from the authorized treating physicians is key to the handling of a workers' compensation claim. It is absolutely imperative that all parties receive return-to-work notices and office notes in order to evaluate how to proceed with the workers' compensation claim. These medical reports that are most helpful contain the: (1)history; (2)examination; (3)diagnosis; (4)treatment; and (5)prognosis. In order for a medical report to be admissible into evidence, it must be signed by the medical provider who issued it. If a party intends to tender a medical report into evidence, the provider's signature does not have to be authenticated as a prerequisite to its admissibility.

## **CHAPTER SEVEN**

### **I. COMMUNICATING WITH REHABILITATION SUPPLIERS**

Some injured employees have rehabilitation suppliers (also referred to as rehabilitation counselors or nurses, case managers, rehabilitation specialists, or rehabilitation professionals). The role of the rehabilitation supplier is to assist the injured employee obtain the best medical care possible, return the employee to suitable employment if appropriate, and aid the employee in regaining as much independence as possible. The treating physician is responsible for the injured employee's medical care. However, a rehabilitation supplier can be invaluable in communicating with other professionals, such as adjusters, employers, and attorneys, that are involved in the workers' compensation claim. The rehabilitation supplier can also help coordinate prescribed adjunct therapy, such as physical therapy, specialized evaluations, pain management, etc. The rehabilitation supplier must provide professional identification to the medical provider and should explain his or her role at the initial visit. Although the rehabilitation supplier is paid by the insurer, he or she should serve as an advocate for the injured employee within the laws and rules of the Act.

Assignment of a rehabilitation supplier is mandatory in catastrophic injury cases. The rehabilitation supplier must be registered with the State Board as a catastrophic rehabilitation supplier to assist the injured worker. The injured employee must cooperate with the rehabilitation supplier that should be assigned very early in the serious injury cases (i.e. spinal cord injuries, amputations, severe brain injuries, severe burns, and blindness). In such cases, the rehabilitation supplier can be immensely valuable in coordinating acute care for the injured worker and serving as the major communicator among the medical providers, family members, treating facilities, payors, and other treating professionals.

If the injured worker's claim has not been designated as catastrophic, a rehabilitation supplier is assigned only if the injured employee and the employer/insurer agree in writing to voluntary rehabilitation. Occasionally a rehabilitation supplier may become involved in a claim, but the injured employee does not want the rehabilitation supplier involved and has not agreed to voluntary rehabilitation. In such cases, you may check with the State Board by calling 404-656-3784 to determine if the claim has been designated as catastrophic and whether a rehabilitation supplier has been appointed by the State Board. If the injury is not catastrophic and the Board has not appointed a rehabilitation supplier and/or the employee and the employer/insurer have not signed a written agreement for voluntary rehabilitation, a rehabilitation supplier should not communicate with a medical provider in person or in writing about the employee's claim. This section does not apply to case managers assigned to employees covered by certified Workers' Compensation Managed Care Organizations; see the section on Managed Care. State Board personnel will be happy to help you sort out any confusion about rehabilitation suppliers and case managers operating under a Board certified WC/MCO.

The injured employee has an absolute right to a private examination and/or consultation with a medical provider. The rehabilitation supplier must advise the injured employee of the right to the private examination/consultation. The rehabilitation supplier cannot attend the examination except by the revocable written consent of the employee or the employee's attorney. Additionally, the rehabilitation supplier should not obtain medical information about the injured employee in a private meeting with a medical provider, unless the rehabilitation supplier has reserved sufficient time for the conference and has given the employee or the employee's attorney notice of the appointment. The employee and/or the employee's attorney has the right to attend the scheduled meeting. If the injured employee or the medical provider does not consent to

the joint meeting, or if the medical provider believes a joint meeting is medically contraindicated, the medical provider should notify the rehabilitation supplier, and at the point, speak directly with the rehabilitation supplier. In any event, the rehabilitation supplier is responsible for reporting to all parties and the employee's attorney the substance of any communication between the medical provider and the rehabilitation supplier.

As a general rule, it is usually best for the medical provider to talk with the rehabilitation supplier after the employee's private examination and *with the employee present*. As a result, the injured employee hears exactly what the medical provider tells the rehabilitation supplier, and will not feel that the medical provider has been talking about the employee behind his or her back, or told the rehabilitation supplier something different from what was told the injured employee. This issue arises most commonly regarding return to work issues, when it is especially important that the injured employee and the rehabilitation supplier understand exactly whether the employee is released to return to work and whether any work restrictions apply. Job analyses of proposed jobs should be discussed jointly with the injured employee and his rehabilitation supplier.

Additionally, a rehabilitation supplier should not act on verbal information alone. Therefore, the medical providers should provide written opinions and make sure that the rehabilitation supplier gets them timely. The rehabilitation supplier must provide copies to all parties of any written communications to and from medical providers regarding the injured employee and report to all parties any and all oral communications. Since the rehabilitation supplier has a right to medical records of the injured employee, often the rehabilitation supplier is the fastest means of distributing medical notes and treatment recommendations to all concerned parties.

## **CHAPTER EIGHT**

### **I. HOW TO SUCCEED IN A WORKERS' COMPENSATION PRACTICE**

#### **-- THE PHYSICIAN'S PERSPECTIVE --**

It is most important to first decide if you are truly interested in caring for workers' compensation patients. There is an extra time commitment, extra paperwork, and issues which are not routinely a problem in non-workers' compensation patients. You must decide if you are able/willing to treat only clear-cut cases or also those with nonspecific or vague symptoms. You must decide if you are willing to take on a larger role in dealing with parties other than your patient. It helps to have an interest in prevention, education, and conflict resolution.

As a physician involved in treating occupational problems, you will have the following tasks:

- 1) Diagnosis
- 2) Contributing factors – work vs. other
- 3) Treatment program to include work status, with time frames.
- 4) Legal issues – causality, impairment, etc.
- 5) Prevention
- 6) Education – all parties.

Education must be part of your overall program. Time frames for treatment interventions should be established, emphasizing active patient participation rather than passive modalities. Re-evaluation every 3-4 weeks is appropriate, and if a given treatment is not working, reconsideration of the diagnosis or consideration of other treatment methods should be done. The concept of “functional restoration” – positive

results defined as functional gains which can be measured – is useful, rather than focusing purely on pain relief. Aggressive physical rehabilitation is often helpful.

Surgery must be done within the context of functional outcome, not just pain relief. Surgery should be based on a positive correlation between clinical findings, clinical course, and diagnostic tests.

A six-month time frame should be emphasized, since it is known that the prognosis for return to work after six months of disability becomes poor. Successful return to work can take place even in the face of chronic pain. In patients failing to make expected progress 6-12 weeks after an injury, strongly consider a psychologic screen and initiation of case management.

Fairness is the key to success. Evaluate each patient thoroughly, objectively, and honestly and treat the patient with respect as you would any other patient. Try to consider the “big picture” and be impartial. Avoid consistently taking one side or the other; deal with problems on a “case-by-case” basis.

Document everything, including phone calls, and address all important issues, especially work status. Go out of your way to expedite communication. Be accessible. Identify problem cases early and try to get case management underway. The key to a win-win situation lies in prompt treatment and early, safe return to work. This can be accomplished with communication, early and often.

In dealing with problem cases, it is not always possible to return the patient to their pre-injury job.

Reasons for this may include:

- 1) Some legitimate patients cannot safely return to their previous work.
- 2) Some employers are not willing/able to accommodate restrictions.
- 3) A small percentage of patients are true malingerers, but a larger percentage fall into one of several categories such as:

- a. overt psychological disorders
- b. “fragile” patients
- c. dissatisfied or disgruntled workers
- d. symptom magnification or somatization.

A vicious cycle sometimes occurs in patients with work-related symptoms. The patient has a symptom that is perceived as disabling. Secondary gain (financial or psychologic) occurs resulting in illness behavior. The patient must maintain their symptoms to maintain their disability and a downward spiral ensues. These strong psycho-social behaviors can occur in response to pain and sickness, but are not mandatory. Avoidance behaviors tend to develop as part of chronic disability. Medical interventions can help to promote wellness behavior and decrease pain behaviors. Persistent interventions which focus purely on pain reduction are not effective in these patients. Reinforcing areas of normal function as opposed to suggesting that activities are “dangerous” can promote wellness. It is important to identify underlying psychological factors early and to get those patients screened. Patients who are dissatisfied with their jobs due to low pay, boring tasks, lack of control, or conflicts with co-workers are difficult to rehabilitate. This is the group that frequently has motivational problems preventing successful return to work.

An aggressive, time-limited physical rehabilitation program with short-term psychological intervention may be successful. However, if the patient or legal representative is unwilling to participate, a settlement may be the ultimate outcome. The most important role for the medical provider in these cases is to identify them early, treat specific physical problems and rehabilitate, and make a disposition as soon as possible.

## **CHAPTER NINE**

### **I. CLINICAL HISTORIES AND CLINICAL EXAMINATIONS**

#### **A. INTRODUCTION**

The clinical history and the general, and then specialty, examination are crucial to defining the specific diagnosis or diagnoses that the worker/patient has. In some specialties the diagnosis can be strongly suspected on the basis of the history alone, and then the physical exam can help confirm it. Diagnostic testing can then help delineate the specifics of the diagnosis and help lead to specific selective criteria for therapeutic interventions. The extent of the history, general medical background and physical exam will, of course, depend upon the type of assessment being done. For instance, a “second opinion” will be different in its content and format from an independent medical evaluation. Nonetheless, certain items are central and crucial to proper diagnosis and treatment, within the workers’ compensation system.

#### **B. ISSUES OF CAUSALITY**

From the first element of the history that is taken, one needs to keep in mind how the injury occurred and how it may be related to the patient’s work activities, or whether it happens to be independent of a work injury. A comprehensive history is important, but those components that are related to the work site injury need to be delineated specifically.

#### **C. SPECIFIC JOB DUTIES**

While going through the history, it is important to have an idea of what type of work the patient does and what the physical demands are for their usual work. This will help highlight issues of causality, and it will

also help delineate return-to-work issues for full or modified duty even from the onset of the first initial visit. Details regarding the patient's specific job can help with both short-term and long-term return-to-work issues. This is particularly true for complex or more severely injured patients who may require significant modification of their original position or change of position to a modified light-duty position permanently. Increased risk of re-injury after the patient has been brought to maximal medical improvement must be considered as well.

#### **D. SPECIFIC TYPES OF NEW PATIENT EVALUATION**

**1. SECOND OPINION OR ONE-TIME EVALUATION:** In general, this is a fairly focused assessment, usually looking at whether a specific therapeutic intervention would be appropriate and that the diagnosis is commensurate with the proposed intervention. An example would be whether the patient would be a candidate for a specific type of spine procedure. The history and physical exam can be focused upon the specific area of interest for the most part with some lesser assessment of general medical and other work-related features. The impression and medical decision making section should be aimed at this as well, specifically addressing the diagnosis, and whether the therapeutic intervention proposed is appropriate and likely to give improvement of the patient's condition.

**2. NEW PATIENT EVALUATION/VARIABLE COMPLEXITIES:** In this instance, the patient is referred to be treated either as an additional treating or as the primary authorized treating physician. In these cases, a broad understanding of the patient's general medical status along with the specific primary complaint or complaints are all essential in order to treat the patient in a wholistic fashion along with the

specific treatment for the work-related injury. The aim of treatment is the best recovery and the best functional status for a return to work. Therapeutic interventions, including medications require an adequate and broad understanding of the patient's general medical health.

### **3. INDEPENDENT MEDICAL EVALUATION/INDEPENDENT MEDICAL**

**EXAMINATION:** This is the most comprehensive and in-depth assessment of the worker/patient and should be designed to illuminate questions of diagnosis, treatment, causality, and other medical/legal/comp issues. An IME is commonly done in complex or unusual cases or in cases where therapeutic progress seems to be stymied. It may also be done if specific therapeutic interventions are suggested and more in depth recommendations are being requested in regards to the appropriateness of diagnosis and treatment, sometimes with very specific medical and legal questions in regards to treatment intervention and/or medical status. Causality issues can be highlighted in an independent medical evaluation with further extended history and correlation to outside studies/x-rays and/or extensive records.

**4. FOLLOW UP VISITS/VARIABLE COMPLEXITIES:** Follow up visits to a certain degree recapitulate some of the primary history and physical exam features of a new patient examination, but, usually in a partial and more focused format, including the more germane immediate details about ongoing diagnosis or intervention components. Physical examination features are also more focused on specific ongoing signs and symptoms and results of therapeutic interventions. The impression and medical decision making section, again, is focused on the most active problems. Follow up visits will vary from quite simple to complex.

## **E. INDEPENDENT MEDICAL EXAMINATIONS**

We will use the IME as the most extensive example of a patient assessment. Parts of this more extensive format would be used for typical new patient examinations, second opinions, out patient consultations, one-time evaluations, etc. Each specialty would choose the specific areas to highlight or give less emphasis to depending upon the clinical evaluation requested and the complexity of the problem.

**1. CHIEF COMPLAINT:** This is a short statement by the patient, in his or her own words, to describe their main presenting complaint. For a workers' compensation claim, this would generally include the date of the injury, what body parts were affected, and what major interventions have already occurred. It may also include the main clinical question or main referral item.

**2. PAST SPECIALTY HISTORY:** It is extremely important, prior to going into the history of present illness of this injury, to understand the patient's baseline condition and any other prior injuries that have occurred. This would include prior work injuries, underlying pre-existing conditions in the specialty area of interest, and general medical conditions that would contribute to or affect this type of work-related injury. It can also include prior motor vehicle accidents, sports injuries, and prior surgeries in the current area of interest. It is, in essence, gaining an understanding of the patient's underlying baseline state prior to the index injury for which he or she is being referred. Both in medical and in causality issues, one must have this baseline understanding of the patient prior to his or her current injury before one can understand what has arisen from the index injury.

**3. HISTORY OF PRESENT ILLNESS:** This should include a detailed phenomenologic and chronologic history brought out from the patient by the examiner illustrating the specific index injury for which he or she is referred for assessment and treatment. Details of the patient's specific job and how the injury occurred, as well as the interim history and treatment which has occurred, will be crucial to include here. Specific physicians who treated the patient and specific tests or therapeutic interventions should be documented in detail. With the examiner's help, the patient should be able to outline benefits or changes or worsenings with various interventions and time. Since many workers injure multiple parts of the body, segregating or segmenting the history and therapeutic interventions here helps to delineate the impression and therapeutic intervention suggestions.

**4. PAST MEDICAL HISTORY:** As with all injuries, a workers' compensation injury does not occur in a "vacuum." Many patients have prior existing general medical conditions that may play a part both in the generation of the work injury or in its treatment. The patient's past surgeries, past major medical problems, and ongoing/intercurrent medical conditions can greatly affect therapeutic interventions, procedure, surgeries, etc. A knowledge of the patient's current medications, drug allergies, tobacco, alcohol, street drug abuse potentials, HIV risk factors, blood transfusions, etc., is important. Family history of inheritable disorders would be important as well. Review of systems can be helpful in screening areas that may have been less highlighted by the patient's history, and social history can be helpful in looking at vocational potential, particularly educational background, etc.

**5. REVIEW OF OUTSIDE FILMS:** To have the best understanding of the patient's current condition, the examiner should read the actual films themselves and be expert at reading those films that are germane to the examiner's area of clinical expertise. Radiographic reports cannot always be relied upon, and an examiner who can read the films themselves and correlate them directly at the time of the visit with the clinical picture will be more accurate in the diagnostic impression and the therapeutic recommendations.

**6. REVIEW OF OUTSIDE RECORDS:** When issues of causality, issues of historical accuracy and specifics of prior interventions are crucial, going through records that may be extensive can be extremely important. Obviously, with a simple initial evaluation, new patient evaluation or second opinion, it may be less important than an independent medical evaluation where more comprehensive issues need to be brought into the assessment. Abstraction, illustration and transcription of some of the primary issues in the past medical records could help if they are included in the IME report itself. Past clinical examinations can reveal both lack of findings and positive findings that would be important in illustrating the patient's current clinical status, particularly worsening or improvement of their condition.

**7. GENERAL PHYSICAL EXAMINATION:** There are some general physical exam features such as heart, lung, bowels, etc., that need to be assessed briefly along with specific areas that are of interest. For instance, the musculoskeletal system, that is not part of the specialists area of main interest, but is germane to the type of injury presented. Hence, the general physical exam tends to be limited to the pertinent or more important general physical examination features.

**SPECIALTY PHYSICAL EXAMINATION:** In this area, the specialist's area of expertise looks in more focused fashion upon the specific disorder/injury in question. This may, for instance, be more spine related or more peripheral nerve related or joint related, etc. The most exacting examination details would be in this section and would be included in detail enough to include pertinent positives and pertinent negatives.

**9. IMPRESSION/MEDICAL DECISION MAKING SECTION:** This is the area that all the historical, physical exam, x-ray, and record review aspects are brought together into statements of diagnoses and therapeutic intervention suggestions. Since many of the complex cases have multiple diagnoses instead of a single diagnoses, in an IME particularly, segmenting out the diagnostic entities and the therapeutic recommendations is the best approach. Of course, if this is a second opinion or has a specific therapeutic question asked at the time of referral, focusing upon that after the diagnosis has been delineated would be appropriate. This is also the section where causality issues and issues integrating pre-existing conditions, etc., should be woven into the various pertinent sections. This should be a useful working document that would provide his examiner or other examiners and treating clinicians with a "road map" to diagnosis or therapeutic interventions. If requested, this section could also include workers' compensation issues such as maximum medical improvement, permanent partial disability, and other legal or clinical questions posed by the referral or treating providers that sent the patient. This is also the section to delineate those diagnostic tests that are missing or need to be done to make a firm diagnosis. Work capabilities are discussed here, including various job modifications suggested or working capabilities or

significant limitation, particularly vis-a'-vis the patient's primary occupation, but also, in general, short-term and long-term vocational aspects.

**10. IME ADDENDUMS:** If the patient requires further diagnostic testing, or various elements of the x-ray or records were not available at the time the patient was seen, these components can be assessed at a later date in the form of an addendum with a clinical correlation.

**11. SUMMARY:** The delineation of accurate historical and examination features are crucial to bringing together all the medical and work-related issues to make the best and most efficacious intervention to treat the patient and improve his or her condition as much as possible, and to improve his or her function so as to best optimize the chance for a return to a more normal personal and work life. Selective testing compliments historical and examination features, but are not a substitute for a good history and examination. The patient's medical status, as well as his or her long-term vocational capabilities, are reliant upon this process. Medical interventions here can make a major impact on both the employee and the employer's situations.

## **CHAPTER TEN**

### **I. MEDICAL FRAUD IN WORKERS' COMPENSATION**

In 1995 the Georgia General Assembly passed legislation giving the State Board authority to create a fraud/compliance division. This division became fully staffed in September of 1995 and since that time the division's primary goal has been to "educate and assist businesses, medical providers, and other individuals involved in the workers' compensation system to achieve a climate which will assure that legitimately injured workers receive benefits allowable under Georgia Workers' Compensation Law." To accomplish this goal, the division investigates and prosecutes both fraud and noncompliance through the state. The State Board serves over 187,000 employers and 3,380,724 workers with an average of 45,000 cases being filed per year. These cases generate an excess of \$300 million in total payment per calendar year. Given that amount of workers' compensation dollars, there is a potential for fraudulent acts in the workers' compensation system.

To date most costly type of workers' compensation fraud in Georgia is provider fraud. Physicians, attorneys, and other medical providers can be guilty of (1) submitting fraudulent bills for services; (2) overstating accident treatment; (3) recruiters or kick-backs; and (4) elaborate schemes to receive additional payments. It has been reported that with the ever-tightening circle of medical cost management, some of the newer forms of medical provider fraud include kick-backs from specialists and other treatment providers to referring physicians and provider up coding. Medical providers also shift from the less expensive, all inclusive patient reports to supplemental reports, which add evaluations and incur separate charges. Medical provider schemes have also included: "creative billing" - billing for services not

performed; “self-referrals” - medical providers who inappropriately refer a patient to a clinic or laboratory in which the provider has an interest; “up coding” - billing for a more expensive treatment than the one performed; “unbundling” - performing a single service but billing it as a series of separate procedures; and “product switching” - a pharmacy or other provider bills for one type of drug but dispenses a cheaper version, such as a generic drug.

The Georgia General Assembly enacted a specific code section dealing with legal and medical fraud in workers’ compensation. O.C.G.A. §34-9-22 provides that “any physician, attorney, or hospital which receives any fee, other consideration, or any gratuity on account of services rendered under this chapter, unless such consideration or gratuity is approved by the Board, or upon appeal, by the Superior Court, or any person who makes it a business to solicit employment for a lawyer or physician or for himself with respect to any claim or award for compensation under this chapter shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished for each offense by a fine not to exceed \$5,000.00 or by imprisonment not to exceed one year, or by both such fine and imprisonment.” There are other code sections dealing with misrepresentations and civil penalties for any person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying any benefit under the Act.

## **APPENDIX WORKERS' COMPENSATION DEFINITIONS**

**Accepted claims:** Those claims that have been accepted as compensable by the employer/insurer as having arisen out of and in the course of employment. In accepted claims, the employee is generally receiving medical care, weekly indemnity benefits, or both.

**Aggravation of Injury:** Aggravation of a pre-existing condition which may be the result of a prior work-related injury, non-work related injury, underlying disease, or otherwise that has been aggravated by a work related injury.

**ALJ (Administrative Law Judge):** An administrative law judge is in effect the judge and jury in a workers' compensation claim. The entire claim is held before and decided by an ALJ.

**All-Issues Claim:** Claim that seeks compensation for medical and income benefits. [O.C.G.A. §34-9-82].

**Arising Out Of:** Causal origin of an accident. [O.C.G.A. §34-9-1(4)].

**ATP (Authorized Treating Physician):** The physician who manages all the treatment of an injured worker. All referrals to other medical providers must be made through an ATP.

**State Board:** State Board of Workers' Compensation. [O.C.G.A. §34-9-1(1)].

**Catastrophic Injury:** An injury of a nature and severity that prevents the employee from being able to perform his or her prior work and any other work for which the employee is qualified. In addition, specific injuries such as spinal injury, amputation, or severe closed head injuries are set forth in O.C.G.A. §34-9-200.1(g).

**Change in Condition Claim:** Claim that alleges a change in condition of a work related injury. [O.C.G.A. §34-9-108].

**Change of Physician:** Ability of the employee or employer to request a different authorized treating physician. [O.C.G.A. §34-9-201].

**Compensation rate:** The weekly indemnity compensation rate an employee receives, based upon a rate of two thirds of his/her average weekly wage with a \$400.00 per week cap.

**Controvert:** The method used to deny an overall workers' compensation claim or a specific issue or medical treatment/test.

**Employee:** Every person (1) in the service of another (2) under any contract of hire or apprenticeship, written or implied. [O.C.G.A. §34-9-1(2)].

**Employer:** "[A]ny individual, firm, association, or public or private corporation engaged in any business ... " [O.C.G.A. §34-9-1(3)].

**Exclusive Remedy:** Workers' compensation is the exclusive remedy for workers whose injuries arise out of and in the course of their employment in Georgia, as opposed to common law tort remedies that preceded the implementation of the workers' compensation system. [O.C.G.A. §34-9-11].

**Fee Schedule:** The schedule determined by the State Board of Workers' Compensation that limits medical expenses to the usual, customary and reasonable charges pursuant to O.C.G.A. §34-9-205.

**Fictional Accident Date:** Pre-existing condition may be "aggravated" without a "specific accident" or even if the physical exertion in which the employee engaged on the job was not unusual or excessive. New accident is distinguished from change in condition where employee injured while working for one employer but becomes disabled while working for subsequent employer. Elements are as follows: (1) duties performed for subsequent employer independently aggravate prior condition; (2) duties performed for subsequent employer are beyond usual, ordinary, or normal limits of prior employment; or (3) duties performed for subsequent employer are more strenuous or exceed limits of light duty work offered by prior employer.

**Independent Contractor:** A person who has (1) a written contract as an independent contractor and (2) if such person buys a product and resells it, receiving no other compensation, or such person otherwise qualifies as an independent contractor. [O.C.G.A. §34-9-1(2)].

**In the Course of Employment:** Time, place and circumstances of accident in relation to employment. [O.C.G.A. §34-9-1].

**Liability Stipulated Settlement:** Stipulated settlement where liability is admitted by employer/insurer.

**Light Duty Work Release:** Release for an employee to return to work with restrictions/modifications.

**Medical-Only Claim:** Claim that includes payment of medical benefits only. [O.C.G.A. §34-9-82].

**Merger:** Merger of an injury with a preexisting permanent impairment... means that (1) had the preexisting permanent impairment not been present, the subsequent injury would not have occurred, (2) the disability resulting from the subsequent injury in conjunction with the preexisting permanent impairment is materially, substantially, and cumulatively greater than that which would have resulted had the preexisting

permanent impairment not been present, and the employer has been required to pay and has paid compensation for that greater disability, or death would not have been accelerated had the preexisting permanent impairment not been present. [O.C.G.A. §34-9-351(1)].

**No-Liability Stipulated Settlement:** Stipulated settlement where no liability is admitted by employer/insurer

**Normal Duty Work Release:** Release for the employee to return to work without restrictions.

**Occupational Disease:** Any disease which arises out of and in the course of employment in which the employee is exposed to the disease. [O.C.G.A. §34-9-201].

**Panel of Physicians:** A list of physicians for employees to utilize for on the job injuries. The list is maintained by the employer and posted in the place of employment. [O.C.G.A. §34-9-201].

**Permanent Impairment:** Any permanent condition due to previous injury, disease, or disorder which is, or is likely to be, a hindrance or obstacle to employment or to obtaining reemployment if the employee should become unemployed. [O.C.G.A. §34-9-351(2)].

**PPD (Permanent Partial Disability):** Disability that is partial in character but permanent in quality, resulting from loss of use of body members or from the partial loss of use of the employee's body. Often referred to in the form of a percentage rating indicating the percentage of loss to a particular part of the body. In Georgia, a PPD rating must be based on the 5<sup>th</sup> edition of the AMA guidelines. [O.C.G.A. §34-9-263.]

**"Rycroft" Defense:** Defense available to employer where the employee misrepresents physical condition and subsequently aggravates a concealed medical problem. Elements of defense are (1) that employee knowingly and willfully made a false representation as to physical condition; (2) that employer relied upon false representation and that this reliance was a substantial factor in hiring decision; and (3) that there was causal connection between false representation and injury or aggravation.

**Third-Party Administrators (TPA):** An organization that assists self-insured employers and some insurance carriers in all aspects of the adjusting of workers' compensation claims.

**Self-Insurer:** Entity that provides worker's compensation benefits to employees through alternative mechanism of group self-insurance program. [O.C.G.A. §34-9-150].

**SITF (Subsequent Injury Trust Fund):** A fund established to encourage employment of the handicapped by protecting employers from excessive liability for compensation for certain injuries occurring to handicapped or otherwise disabled workers.

**Statute of Limitations:** The time period that an employee/employer have to bring a claim for workers' compensation benefits. If a claim is not filed within the requisite time period, benefits may be denied.

**Statutory Employer:** A principal or intermediate contractor is made "statutory employer" of subcontractor's employee. [O.C.G.A. §34-9-8].

**Stipulated Settlement:** Settlement between the parties pursuant to O.C.G.A. §34-9-15 in lieu of a hearing.

**Subrogation:** The right of an employer/insurer to recover compensation and medical expenses paid under workers' compensation for injuries to an employee which are ultimately recovered from a responsible third party.

**Supperadded Injury:** A subsequent condition that develops as a result of the condition originally caused by a compensable injury. There must be a direct causal relationship between the original injury and the ultimate condition.

**Traditional Panel:** "Traditional" posted panel of physicians. List must include at least four physicians and, effective January 1, 2002, 6 physicians must be on the panel. [O.C.G.A. §34-9-201].

**WC-205 – Request for Authorization of Treatment of Testing by the Authorized Medical Provider:** The authorized medical provider may request advanced authorization for treatment/testing by completing Sections 1 and 2 of this form and faxing or e-mailing the form to the insurer/self-insurer. The insurer/self-insurer shall respond to this request within 5 business days of receipt of this form by completing Section 3 of the form.

**WC-207 - Patient Authorization:** Release form which allows the parties to obtain medical records. Employee who has submitted claim or who is receiving treatment pursuant to workers' compensation is deemed to have waived confidentiality of medical records pursuant to O.C.G.A. §34-9-207.

**WC Managed Care Organization “WC/MCO”:** When employer contracts with managed care organization approved by the Board.

**Work restrictions:** Restrictions placed upon an employee's ability to return to work at less than normal duty. Restrictions generally include limitations on lifting, standing, etc. or may refer to the number of hours a claimant can work on any given shift. Work restrictions should include the length of time until they will be removed and whether the claimant needs any special devices or accommodations in order to perform the light duty work.