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Workers' Compensation

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I. LEGISLATIVE CHANGES

The year 1992 brought the most comprehensive workers' compensation reform legislation in two decades.¹ Dramatic changes impact the amount and duration of temporary total disability benefits, the definition of change of condition, vocational rehabilitation services in noncatastrophic cases, and the return of subrogation by employers against third party tortfeasors, as well as many other changes in the workers' compensation system, as detailed below.²

A. Rehabilitation & Catastrophic Injuries

Rehabilitation services to workers suffering injuries that are noncatastrophic are no longer mandatory.³ The parties may agree to rehabilitation, but this will require the agreement of all parties in noncatastrophic injuries.⁴ The parties may agree to rehabilitation, but this will require the agreement of all parties in noncatastrophic injuries.

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¹ House Bill No. 1679 was the culmination of perhaps the most heated legislative debate ever on the issue of workers' compensation.

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cases to participate, since it is no longer required by the Workers' Compensation Act (the "Act"). In catastrophic cases, an employer must either appoint a rehabilitation supplier or provide sufficient reasons that rehabilitation is not necessary within forty-eight hours of an "employer's acceptance of the injury as compensable or notification of a final determination of compensability, whichever occurs later." Therefore, the time periods will not run from the date of injury. Instead, this initial appointment/assessment period will run from the date an employer accepts the claim through the proper form filings or the date of a final award on the issue of compensability. If the issue presented to the State Board of Workers' Compensation (the "Board") is not compensability, but whether a particular injury satisfies the definition of catastrophic, then an employer is provided a full fifteen days from the date of the award in which to appoint a rehabilitation supplier. Thus, employers who accept a claim, but question catastrophic qualification, have an additional two weeks after determination of qualification in which to appoint a rehabilitation supplier. If an employer fails to select a supplier within the time period allowed, the Board may appoint a supplier.

The 1992 legislation broadened the definition of "catastrophic injury" under the Act. Whether a particular injury satisfies the criteria for catastrophic will become a threshold question that impacts many rights and obligations under the Act. Catastrophic injury will include the following:

(1) Spinal cord injury involving severe paralysis . . . ; (2) Amputation of an arm, a hand, a 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; or (F) Other conditions at least as severe in nature as [the designated conditions]; . . . [and] (6) Any other injury of a nature and severity as has qualified or would qualify an employee to receive disability income benefits under Title II or supplemental security income benefits under Title XVI of the Social Security Act . . . .

4. Rule 200.1 of the Rules and Regulations of the State Board of Workers' Compensation provides that once a party agrees to participate in vocational rehabilitation, the agreement cannot be retracted; but this rule appears to exceed the specific, non-binding provision of O.C.G.A. § 34-9-200.1. Ga. Bd. of Workers Compensation R. 200.1 (The Workers' Compensation Act is currently codified at O.C.G.A. §§ 34-9-1 to -38 (1992)).
6. Id.
7. Id.
8. Id.
9. Id. § 34-9-200.1(g). (The Social Security Act is codified at 42 U.S.C. §§ 301-1397e (1988)). Title II, Old-Age Survivors Disability Insurance Benefits of the SSA is codified at
Some changes will probably have only a subtle effect on defining catastrophic injuries. Spinal cord injuries satisfy the criteria only if they involve "severe paralysis of an arm, a leg, or the trunk." Amputations need not be to more than one appendage any longer, as the Act formerly required, but they must involve the "effective loss of use" of an arm, hand, foot, or leg. Brain or closed head injuries must be evidenced in one of five specific ways and must be "severe."

The broadest definitional expansion of catastrophic injuries is in the inclusion of claimants who meet the criteria of Title II or Title XVI of the Social Security Act. Generally, the Social Security Act defines disability as the inability "to engage in any substantial gainful [employment or] activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." The physical and mental impairment must be of such severity that an employee is "not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other type of substantial gainful work which exists in the national economy." Title XVI of the Social Security Act defines disability as the aged (over sixty-five), blind as defined in the Act, or disabled as set forth above. Note that any consideration of time limitations under the Social Security Act vis-a-vis the definition of catastrophic under the Workers' Compensation Act is removed.

B. Indemnity Benefits: Increases and 400-Week Cap

The maximum weekly compensation rate for temporary total disability benefits shall be $250 for accidents occurring after July 1, 1992. With respect to temporary partial disability benefits under section 34-9-262 of the Official Code of Georgia Annotated ("O.C.G.A."), the maximum allowable compensation rate has been increased from $150 to $175 per week for accidents occurring after July 1, 1992. Maximum benefits to a sur-
viving spouse who is a sole dependent will increase from $65,000 to $100,000.\textsuperscript{20}

For accidents occurring after July 1, 1992, there are several new qualifications and limitations on benefits. Temporary total disability benefits in noncatastrophic cases “shall be payable for a maximum period of 400 weeks \textit{from the date of injury}.”\textsuperscript{21} This is a time limitation, not a limitation on the number of weeks of disability benefits. In catastrophic cases, there is no 400-week limit and benefits will be paid until “the employee undergoes a change in condition for the better.”\textsuperscript{22} The American Medical Association guidelines shall be the only basis for permanent impairment ratings.\textsuperscript{23}

C. The New Change of Condition

Traditionally, the threshold question in assessing the rights and obligations of an employer and employee to ongoing temporary disability benefits has been whether the employee continues to possess physical limitations related to the on-the-job injury.\textsuperscript{24} The inability to perform a particular job in which the worker was engaged at the time of the injury is not a determining factor. Historically, a determining factor has been the worker’s inability to find any work suitable to the worker’s condition as a result of the work-related injury and compatible with his or her training and experience.\textsuperscript{25} Furthermore, the existence of a permanent impairment rating entitling an employee to permanent partial disability benefits under O.C.G.A. section 34-9-263\textsuperscript{26} does not, \textit{ipso facto}, foist the employee into the category of those entitled to either the payment of temporary disability benefits or the tender of suitable employment. Rather, Georgia law provides that “[i]mpaired earning capacity is not one involving a percentage of disability, but rather impairment that renders claimant unable to return to his regular employment or ‘to procure remunerative employment at a different occupation suitable to his impaired

\begin{itemize}
  \item \textsuperscript{20} Id. § 34-9-265(d).
  \item \textsuperscript{21} Id. § 34-9-261 (emphasis added).
  \item \textsuperscript{22} Id.
  \item \textsuperscript{23} Id. § 34-9-1(5) (No longer may permanency ratings be based upon recognized medical books or guides other than the AMA Guidelines.).
  \item \textsuperscript{26} O.C.G.A. § 34-9-263 (1992).
\end{itemize}
capacity.' If the impairment prevents that return then his disability is total."27

Under Georgia law, when an employee suffers an on-the-job injury, returns to gainful employment, and subsequently seeks the recommencement of temporary disability benefits, the burden of proof is on the employee to show a change in condition.28 However, if an employee is collecting temporary disability benefits for either temporary total disability or temporary partial disability, the burden of proof has traditionally been upon the employer to justify the suspension of benefits.29

One of the most significant legislative changes is the addition of a new type of change in condition.30 This provision provides for a change in condition for better entitling the employee to only temporary partial disability benefits under O.C.G.A. section 34-9-262 when the following criteria are met: (1) "the injury is not catastrophic"; (2) "the employee is not working"; (3) "the employee has been capable of performing work with limitations . . . for 52 consecutive weeks" or seventy-eight weeks in the aggregate; and (4) "within 60 days of the employee's release to return to work with . . . limitations," the employer gives notice to the employee on a form provided by the Board of the release to return to work and an explanation of the limitations or restrictions.31 Under these specific terms, an employer/insurer may convert the claimant's benefits from temporary total disability payments to temporary partial disability benefits.32 Failure to give notice of the release to return to work with limitations should result only in preventing the conversion of benefits in less than seventy-eight aggregate weeks, since O.C.G.A. section 34-9-262 provides that "[i]n no event shall an employee be eligible for more."33

In this situation, calculating the amount of temporary partial disability benefits owed under O.C.G.A. section 34-9-262 is unique in that the claimant has not actually returned to work. Temporary partial disability benefits were originally intended and traditionally utilized as a supplement for workers injured on the job who return to work at diminished

31. Id.
32. Id.
33. Id. Note that Rule 104 of the Rules and Regulations of the State Board of Workers' Compensation provide that neither the 52 nor 78-week periods will commence absent proper notice, but this Rule clearly conflicts with the statute. GA. BD. OF WORKERS COMPENSATION R. 104.
wages as a result of the on-the-job injury. The formula presently mandated by section 34-9-262 requires the payment of “two-thirds of the difference between the average weekly wage before the injury and the average weekly wage the employee is able to earn thereafter, but not more than $175 per week for a period not exceeding 350 weeks from the date of injury.”

Therefore, an employee is earning nothing. Weekly benefits payable under O.C.G.A. section 34-9-104(a)(2) are different from temporary total disability benefits in only two ways. First, the maximum is $175 rather than $250 per week. Consequently, any employee with an average weekly wage more than $262.50 will experience a reduction in benefits to the maximum rate of $175. Conversely, employees with an average weekly wage of less than $262.50 will not experience a reduction of the weekly benefit. However, the cap on temporary partial disability benefits runs 350 weeks from the date of injury rather than 400 weeks provided for noncatastrophic temporary total disability benefits.

Nothing in O.C.G.A. section 34-9-104(a)(2) prevents an employee from having a change in condition in the traditional sense at any time, either before or after the fifty-two consecutive weeks or seventy-eight aggregate weeks in which the claimant was capable of performing work with limitations or restrictions. For example, if an employer shows the absence of any limitation related to the on-the-job injury, then temporary disability benefits may be suspended at any time without a showing of the availability of suitable employment. In those situations in which an employee still suffers limitations in the performance of gainful employment that are related to the on-the-job injury, an employer may show the availability of suitable work to suspend the payment of temporary benefits without regard to the fifty-two consecutive or seventy-eight aggregate weeks. Likewise, if an employee experiences a change in condition for the worse such that he or she becomes totally disabled, then an employee again will be entitled to the payment of temporary total disability benefits under O.C.G.A. section 34-9-261.

35. For the compensation available for total disability, see O.C.G.A. § 34-9-261 (1992).
36. \( \frac{2}{3} \times (\text{AWW} - \delta) = \text{TPD} \), but no more than $175.
38. Id. § 34-9-104(a)(2).
D. Access to Medical Records

O.C.G.A. section 34-9-207 has been added to facilitate the collection of medical data.\textsuperscript{42} Two situations trigger this section: (1) "When an employee has submitted a claim . . . or is receiving . . . income benefits," or (2) when "the employer has paid any medical expense."\textsuperscript{42} In either event, an employee is deemed to have waived "any communication related to the claim or history or treatment of injury arising from the incident"\textsuperscript{44} between the employee and any physician, "including information relating to treatment for any mental condition or drug or alcohol abuse."\textsuperscript{45} This waiver is not limited strictly to any "communications related to the . . . injury arising from the incident."\textsuperscript{46} The statute must be applied in its entirety and specifies that the waiver is for any communications concerning the "history or treatment" and directs that "the employee shall provide . . . all information and records related to the examination, treatment, testing, or consultation concerning the employee."\textsuperscript{47}

There are two procedures created for obtaining records. First, an employer is entitled to make a simple request for medical records from "any physician who has examined, treated, or tested the employee."\textsuperscript{48} Furthermore, the section leaves no discretion to the physician on whether or not to produce the records, but directs that the physician "shall provide within a reasonable time and for a reasonable charge all information and records . . . ."\textsuperscript{49} Acknowledging the practical difficulty of obtaining records without a written authorization, not to mention the requirements of certain federal privacy laws, the legislature established a procedure whereby "the employee [is required to] provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse."\textsuperscript{50} The only specific requirement on the language of the release is that it "shall designate the provider and shall state that it will expire on the date of the hearing."\textsuperscript{51} In the event any employee refuses to provide such a release, any income benefits being received "shall be sus-

\textsuperscript{42} Id. § 34-9-207.
\textsuperscript{43} Id. § 34-9-207(b).
\textsuperscript{44} Id. § 34-9-207(a).
\textsuperscript{45} Id. § 34-9-207(b).
\textsuperscript{46} Id. § 34-9-207(a).
\textsuperscript{47} Id.
\textsuperscript{48} Id.
\textsuperscript{49} Id.
\textsuperscript{50} Id. § 34-9-207(b).
\textsuperscript{51} Id.
pended and no hearing shall be scheduled until such signed release is provided.”

E. Coordination of Benefits

O.C.G.A. section 34-9-243 was modified by the addition of paragraphs (b) through (f) to allow employers to offset weekly benefits by the amount of payments made to an employee under an employer funded disability plan. This section provides that:

The employer's obligation to pay or cause to be paid weekly benefits... shall be reduced by the employer funded portion of payments received... by the employee pursuant to a disability plan, a wage continuation plan, or from a disability insurance policy established or maintained by the same employer... The employer funded portion shall be based upon the ratio of the employer's contributions to the total contributions to such plan or policy.

The offset applies to weekly indemnity benefits, not benefits for permanent partial disability impairment rating. The Board shall establish rules to facilitate the free exchange of information necessary for this coordination of benefits to function, along with reporting requests for any credits taken.

F. Attorney Fees

Several changes in the Act directly impact attorney fees. The legislature amended O.C.G.A. section 34-9-108(a) to limit the amount of recovery of attorney fees to no more than “25% of the claimant's award of weekly [indemnity] benefits or settlement.” The legislature also amended O.C.G.A. section 34-9-108(b)(2) to provide for reasonable quantum meruit attorney fees. In instances when the provisions of O.C.G.A. section 34-9-221 have been violated and an attorney is hired to enforce the employee's rights under the Act, the fee is limited to quantum meruit. The amendments to O.C.G.A. section 34-9-108(c) also provide that an attorney shall not advertise when the attorney or his law firm does not

52. Id.
55. Id. § 34-9-243(f).
56. Id. § 34-9-243(d), (e).
57. Id. § 34-9-108(a). Previously, claimant’s attorney could recover up to 33-1/3% of all indemnity benefits or settlement amounts. See Ga. Bd. of Workers Compensation R. 108(a).
intend to render the full legal services as advertised. Additionally, in only limited exceptions, section 34-9-108(c) prohibits attorneys who are not associates or partners in the same law firm from dividing a fee for legal services.

G. Subrogation

One of the most controversial elements of the 1992 legislation was subrogation, a right that employers enjoyed in the workers' compensation system until its legislative abolition almost two decades ago. The right of subrogation has now returned in a form dictated largely by political considerations, and the result is that the new statute does not set out clear procedural details on enforcing the lien, the right to recovery, or the amount of potential recovery. Subrogation could easily be the subject of a lengthy law review article, but it will be only briefly reviewed in this Article.

An employer/insurer must consider a potential subrogation claim whenever a third party may be liable under tort law to the injured employee or the survivors of the deceased employee. Determining what may be claimed in a subrogation action is complex and requires a look at specific language. O.C.G.A. section 34-9-11.1(b) states that "the employer's or insurer's recovery shall be limited to the recovery of the amount of disability benefits and medical expenses paid and shall only be recoverable if the injured employee has been fully and completely compensated for all economic and non-economic losses incurred as a result of the injury." By specifying only "disability benefits" and "medical expenses," the language leaves unanswered the question of whether the subrogation provision includes rehabilitation expenses, death benefits, or survivors' benefits. The subrogation lien appears to be limited to the amount of compensation paid at the time of settlement with or judgment against the

59. Id. § 34-9-108(c).
60. Id. Fees may be divided between unaffiliated attorneys if:

(1) [t]he client consents to employment of the other attorney after a full disclosure that a fee division will be made; (2) [t]he division is made in proportion to the services performed and the responsibility assumed by each; and (3) [t]he total fee of the attorneys does not clearly exceed reasonable compensation for all legal services such attorneys rendered to the client.

61. Id. § 34-9-11.1.
62. Id. § 34-9-11.1(a).
63. Id. § 34-9-11.1(b).
64. Id.
tortfeasor. The lien does not appear to encompass future obligations that the workers' compensation carrier may have.

Although the statute states that the insurer "may intervene in any action to protect and enforce such lien," the courts may construe this as a command since it affects the rights of third persons. The employer/insurer must recognize that a failure to intervene in a lawsuit, of which it has knowledge and a reasonable opportunity to intervene, may result in a waiver of its subrogation lien.

During the first year after the accident, the employer/insurer's only means of protecting its interests is to intervene in any pending action. The statute is silent as to the consequences of a failure to intervene, but the case law suggests that the employer/insurer should notify the claimant/employee and any potential tortfeasors of its potential subrogation lien as soon as possible. Analogous decisions in no fault subrogation cases strongly suggest that should the injured employee settle the case, a release of the tortfeasor without the consent of the workers' compensation insurer will not bar the subrogation lien. The statute also provides that

65. Id. (emphasis added).
66. Id. § 34-9-11.1(c).
68. In Georgia Farm Bureau Mut. Ins. Co. v. Alterman Foods, Inc., 161 Ga. App. 695, 289 S.E.2d 537 (1982), the court held that the failure to intervene was fatal to the subrogation claim. Id. at 700, 289 S.E.2d at 540. Similarly, in United States Fidelity & Guar. Co. v. Carl Subler Trucking Co., 800 F.2d 1540 (11th Cir. 1986) the no fault insurer paid medical and lost wage benefits under its no fault plan. The injured party filed a personal injury action to recover for mental and physical pain and suffering, and for past, present, and future lost wages. Plaintiff received a $75,000 verdict, which was reduced by $18,000 to reflect lost wage benefits already received from USF&G. The tortfeasor, after being constantly informed both before and after the lawsuit of the amounts that had been paid by USF&G to the injured party, refused to pay USF&G anything, including the $18,000 that had been withheld from the jury verdict. USF&G brought an action against the tortfeasor to recover all sums that it had paid. Id. at 1540-41. The court stated that USF&G had no greater or lesser rights than its insured, and noted that a cause of action for personal injuries cannot be split under Georgia law. Id. The court also stated that since the injured party could not have maintained a separate lawsuit for medical and rehabilitation expenses and could not bring a lawsuit claiming additional lost wages when the issue had already been adjudicated, the no fault insurer was barred from instituting a separate lawsuit because it failed to intervene in the insured's lawsuit. Id. at 1542.

These cases are in contrast to Poole Truck Line, Inc. v. State Farm Mut. Auto. Ins. Co., 163 Ga. App. 755, 294 S.E.2d 570 (1982), in which the court considered the subrogation claim brought by State Farm under the Georgia Motor Vehicle Accident Reparations Act. State Farm's insureds executed a release before State Farm paid any no fault benefits. When State Farm paid its benefits under the No Fault Act, it attempted to recover these benefits by asserting its right of subrogation. Id. at 756, 294 S.E.2d at 570. The question was whether the release, which had been signed before State Farm ever made its payments, affected the right of subrogation. The court noted that "[i]t has long been established that 'no right of subrogation arises until the insurance is paid.'" Id., 294 S.E.2d at 571 (quoting
the insurer may recover only if the injured person is "fully . . . compensated . . . for all economic and non-economic losses incurred as a result of the injury." An employer/insurer cannot necessarily assume that an injured party has been fully compensated by a verdict in favor of the injured party. Under the doctrines of contributory and comparative negligence, which are commonly applicable in bodily injury claims, a jury is instructed that if it finds contributory negligence by the injured party, it should reduce the damages to reflect the fault of the injured party. In such cases, although an injured party may receive a judgment, one may argue that the injured party is not fully compensated for the loss suffered as a result of the injury.

Although not relevant in a workers' compensation hearing, in a tort suit arising from a compensable injury, the injured worker's own negligence is relevant. For example, if an injured worker is forty percent at fault in causing his own injury and the manufacturer of equipment is sixty percent at fault, then the injured worker may be entitled to recover, but his recovery would be reduced to reflect his contributory negligence. It is unknown if this principle will apply to subrogation claims as well. The loss incurred can be very different from the "right to recovery." "Right to recovery" may be discounted heavily to account for comparative negligence. Any verdict or judgment in which a comparative negligence defense was asserted will create problems in defining the extent of the subrogation claim unless the jury makes a finding that comparative

Allstate Ins. Co. v. Austin, 120 Ga. App. 430, 432, 170 S.E.2d 840, 843 (1969)). The court held that the tortfeasor had constructive notice of the statutory right of subrogation because no fault coverage was mandatory in Georgia. Id. at 758, 294 S.E.2d at 572. Accordingly, the court held that those who use the roads were presumed to know the law giving the insured's insurance company "a statutory right of subrogation in accidents involving a vehicle weighing more than 6,500 pounds." Id. Therefore, the court stated that when the tortfeasor sought to settle with the injured party and obtain a release without the insurer's consent, the tortfeasor is doing so at his own risk. Id. The court noted that the tortfeasor could "avoid double payment by withholding from the settlement a sum sufficient to satisfy the insurer's subrogation claim." Id.

69. O.C.G.A. § 34-9-11.1(b) (1992). The language is identical to that used formerly in the No Fault Act, defining the right of subrogation for no fault carriers in accidents involving a vehicle weighing more than 6,500 pounds. Id. § 33-34-3(d) (1990 & Supp. 1991). The purpose of the language in the no-fault statute was to make sure that the plaintiff got first access to the assets of the tortfeasor. That purpose was accomplished in the No Fault Act once any judgment for the injured party was paid and the policy limits were not exhausted. However, the same argument may not apply in the workers' compensation subrogation context.

70. Those resisting a subrogation claim will argue that the subrogor has no stronger claim than the injured party would have had, and therefore, should be subject to the same contributory/comparative negligence rules as the injured party.
negligence was not used to reduce the damages award to the plaintiff, or makes a specific finding as to the amount thereof.

O.C.G.A. section 34-9-11.1(c) provides that any action against another "person by the injured employee or those to whom his right of action survives must be instituted in all cases within one year from the date of injury." The existing two-year statute of limitations for personal injury or wrongful death is not affected, but if the injured party or those to whom the action survives fails to bring the action within one year, this operates as an assignment of the right to the employer/insurer. The employer/insurer may bring the action in its own name, the name of the injured employee, or the name of those to whom the right of action survives. The employer/insurer "may not retain any amount in excess of the limit of recovery" as discussed previously, and any net recovery in excess of the subrogation interest must be paid "to the injured employee or those to whom the right of action survives." O.C.G.A. section 34-9-11.1(d) also provides that in the event of a recovery from a third party, the attorney representing the employee or the employee's survivor "shall be entitled to a reasonable fee for services." If the employer/insurer engages another attorney to represent the employer/insurer in pursuing the action against the third party, then a court, upon application, will apportion fees between the attorney for the employer/insurer and attorney for the employee.

II. THE AMERICANS WITH DISABILITIES ACT

Congress passed the Americans with Disabilities Act ("ADA") and President Bush signed it into law in relative obscurity on July 26, 1990. Referred to by some as an "emancipation proclamation" for the dis-

72. Id. § 9-3-33 (1982).
73. Id. § 34-9-11.1(c).
74. Id.
75. Id.
76. Id. § 34-9-11.1(d).
77. Id. It should be noted that State Bar Ethical Request No. 90-R6 dealt with the hypothetical situation of whether one attorney can properly represent a subrogation interest of an insurance company on a property damage claim while at the same time representing the injured party in a personal injury action. Acknowledging the troublesome nature of allocating any recovery between the liquidated damages of the subrogated property loss and the unliquidated damages of the personal injury claim, the State Bar opined that only "the most sophisticated of insureds could intelligently waive such a conflict" and concluded that attorneys would be precluded from representing both the insurer and the insured "in almost all such cases." Id.
Almost entirely unforeseen at the time this law was passed, however, were the ADA's implications for workers' compensation laws around the country. In attempting to address employment based discrimination against the disabled, the ADA simultaneously has had a significant impact on a number of workers' compensation issues, primarily pre-employment inquiries, return to work issues, and potential retaliatory discharge claims.

A. Pre-Employment Inquiries

At the core of the ADA's protection for the disabled is the prohibition against any inquiry by an employer to an applicant phrased in terms of a disability. This precludes any pre-employment inquiry, in a written application or otherwise, relating to physical or mental impairments, prior injuries, or even prior workers' compensation claims. Apart from drastically affecting how employers may assess the potential insurance risk of a job applicant, the ADA's limitations on pre-employment inquiries raise significant questions about the so-called "Rycroft" defense, and how an employer may perfect a claim against the Subsequent Injury Trust Fund ("SITF" or "the Fund").

In Georgia Electric Co. v. Rycroft, the Georgia Supreme Court established a defense to workers' compensation claims in which the employee makes a knowing and willful misrepresentation concerning his physical condition, the employer relies on the false representation as a substantial factor in hiring the employee, and a causal connection develops between the false representation and a subsequent on-the-job injury. This defense, which exists in numerous jurisdictions around the country, is designed to combat claims that result from fraud in the hiring process. In contrast, claims by employers against the Georgia Subsequent Injury

81. Id. § 12112(c)(2)(A); 29 C.F.R. § 1630.13(b) (1991).
82. 29 C.F.R. § 1630.13(a) (1991).
85. Id. at 159, 378 S.E.2d at 114.
Trust Fund arise from an employer's knowledge of an employee's pre-existing permanent impairment when that condition merges with a job-related injury to create a greater degree of workers' compensation liability. Similar to the ADA, the SITF attempts to promote the hiring of the disabled, and does so by providing reimbursement for those workers' compensation claims that are either caused or accelerated by a pre-existing condition.

Obviously, a key to both a Rycroft defense and a SITF claim is what the employer knew, or did not know, about the employee's physical condition at the time of hire. Typically, this is established at trial by use of the employment application as evidence. The ADA's prohibition against pre-employment inquiry regarding any physical or mental impairment drastically alters how an employer may prove the elements of employer knowledge crucial to Rycroft defenses and SITF claims. This problem, however, ultimately should not prove to be insurmountable to either issue.

Rycroft provides a useful example of how this defense may survive the ADA's prohibition against pre-employment medical inquiries. The employer/insurer's defense in Rycroft was based upon the claimant's misrepresentations regarding a prior back condition and concurrent workers' compensation claim in response to specific questions placed in a written employment application. Since the ADA now prohibits such questions in employment applications, the question arises whether the Rycroft defense is now moot. The answer should be no.

Although the facts of the decision in Rycroft concerned an employment application, the holding itself was based upon the well-settled principle that fraud in the inception of a contract makes the contract voidable. Although the ADA prohibits medical inquiries at the pre-employment stage, it does not prohibit such inquiries made after an offer of employment and before the employee actually begins work, provided that all entering employees in the same job category are subject to the same inquiry. An employer may, therefore, ask the same questions about an employee's physical or mental condition after the offer of employment is made as it may formerly have asked in a pre-employment application or

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88. Id. § 34-9-350.
89. Id.
91. Id. at 156, 378 S.E.2d at 112.
92. Id. at 159, 378 S.E.2d at 114. As the court stated: "it is a historically sound principle of law that a contractual relationship procured through fraud makes the contract voidable at the behest of the injured party." Id. (citing O.C.G.A. § 13-5-5 (1988)).
interview. In fact, ADA guidelines published by the Equal Employment Opportunity Commission ("EEOC") specifically recognize an employer's need to collect information for subsequent injury fund claims as a legitimate business purpose in post-offer medical inquiries and examinations.\textsuperscript{44}

Assuming, therefore, that the claimant in \textit{Rycroft} lied about his physical condition in a post-offer medical inquiry, rather than in a pre-employment application, the result should be no different. The supreme court supported its decision in \textit{Rycroft} by stating that "there is a presumption that an employer takes an employee as he finds him, the courts cited above have found it persuasive that an employer be able to rely on the employee's description of his physical condition."\textsuperscript{48} Clearly, an employer's reliance on a post-offer medical inquiry is no less real than the reliance in \textit{Rycroft}. Moreover, with the prohibitions and remedies provided by the ADA, there should be less incentive for an employee to conceal or misrepresent a pre-existing condition.

The ADA's effect on potential SITF claims will be less dramatic than with \textit{Rycroft} defenses. Unlike the issue in \textit{Rycroft}, SITF claims never have been dependent on employer knowledge at the pre-offer stage. The fact that employment applications have been frequently used to prove employer knowledge of a pre-existing condition is simply a by-product of medical inquiries on previous employment applications. Employers who conduct their medical inquiries in compliance with the ADA will continue to be able to establish their knowledge of an employee's pre-existing condition. Because such inquiries now will be more specifically directed at potential SITF claims, and at making reasonable accommodations under the ADA for disabled employees,\textsuperscript{46} proving employer knowledge in SITF claims may actually become easier.

\textbf{B. Return to Work Issues}

One of the primary purposes of any workers' compensation act is the ultimate return of the injured workers to active employment.\textsuperscript{97} Although returning the injured worker to employment is advantageous to both parties, doing so is largely aspirational under Georgia's Workers' Compensation Act. An employer, for example, may elect to simply pay a claimant disability benefits or help him find work with another employer rather than modifying his former job or placing him in another light-duty posi-

\begin{itemize}
\item \textsuperscript{44} 29 C.F.R. § 1630.14(b) (1991).
\item \textsuperscript{45} 259 Ga. at 159, 378 S.E.2d at 114.
\item \textsuperscript{46} The ADA requires that employers provide "reasonable accommodation" to disabled employees. 42 U.S.C. § 12112(b)(5)(A) (Supp. II 1990).
\item \textsuperscript{47} O.C.G.A. § 34-9-200(a) (1992) for example, requires employers to furnish injured employees medical care and "other treatment" that is both reasonably required and likely to effect a cure, give relief "or restore the employee to suitable employment." \textit{Id.}
tion. The ADA, however, alters an employer's obligations in dealing with injured employees.

The ADA requires that employers provide "reasonable accommodations" to the disabled, including those employees who have been injured on the job. The ADA's definition of "reasonable accommodation" includes "job restructuring, part-time or modified work schedules, reassignment to a vacant position, [and] acquisition or modification of equipment or devices." The "reasonable accommodation" requirements of the ADA clearly impose a new burden on employers to accommodate injured workers with light-duty employment when appropriate. This new burden, however, is not without limitations.

The EEOC has stated that an employer is not required to reallocate the essential functions of a job, but rather only marginal functions, in order to provide a reasonable accommodation. The EEOC uses the example of a security guard who develops a visual impairment and is thereafter unable to inspect company identification cards. Since inspecting identification cards is essential to the security guard position, the employer would not be obligated to modify the security guard job to accommodate the employee's visual disability. If the disability only affects more marginal aspects of the job, however, (for example filling out written reports) restructuring of the job would be appropriate as a reasonable accommodation, since this aspect of the job is not necessarily essential. In addition, the ADA does not require that an employer create a new job or remove another employee from an existing job to provide reassignment as a reasonable accommodation. An employer is not required to promote an individual with a disability to make such an accommodation.

Although the EEOC has attempted to establish some guidelines as to what exactly constitutes a "reasonable accommodation," it is apparent that this vague term will be the subject of substantial litigation. Exactly how far an employer must go to provide a "reasonable accommodation" to injured employees is uncertain at present, but there can be no doubt that this provision of the ADA will significantly affect how employers approach return to work issues under the Act.

99. Id. § 12111(9)(B).
100. EEOC TECHNICAL ASSISTANCE MANUAL, APPENDIX B: EEOC TITLE 1 REGULATIONS AND INTERPRETIVE INDEX B-23 (1992).
101. Id.
103. EEOC TITLE 1 REGULATIONS AND INTERPRETIVE INDEX, at B-23-24.
104. Id. at B-24.
C. Retaliatory Discharge

Another potentially unforeseen impact of the ADA is the creation of what amounts to a federal retaliatory discharge statute. Such statutes typically provide a remedy outside the workers' compensation act when the employee has been terminated in retaliation for the bringing of a workers' compensation claim. Georgia law, which follows the "at-will" employment doctrine, has not yet recognized a separate statutory remedy for retaliatory discharge claims. The ADA, however, effectively supplies a remedy when an employer terminates an injured worker solely because of a disability, job-related or otherwise. The termination of an employee in retaliation for filing a workers' compensation claim would constitute an employment action taken because of a disability on the part of the employee, and thus, would be illegal under the ADA. Undoubtedly, the presence of such a remedy will spark additional litigation when termination occurs during, or shortly after, a heated workers' compensation claim.

One should not assume, however, that the ADA provides a remedy for every termination that occurs after the filing of a workers' compensation claim. Although the ADA imposes a duty upon employers to provide reasonable accommodations, it does not absolve employees from complying with other duties properly imposed by the employer. For example, discovery that an employee committed fraud in the workers' compensation process may constitute valid grounds for termination that would not lead to an ADA remedy. Moreover, if the injured worker had been out of work for a long period of time, and his former position had to be filled by the employer, and no other jobs were available, the employer would not necessarily be obligated under the ADA to create a position for the claimant.

The various remedies available under the ADA will undoubtedly affect how employers approach workers' compensation claims, since, unlike other federal discrimination laws, the ADA will overlap to a great extent with workers' compensation. As the ADA is interpreted by federal courts, workers' compensation practitioners should take note and be alert to potential repercussions in the workers' compensation system.

108. Id. § 12111(9); see supra note 102 and accompanying text.
III. CASE LAW DEVELOPMENTS

A. Any Evidence

During previous survey periods, the court of appeals issued numerous decisions involving the “any evidence” rule. In Elbert County Board of Commissioners v. Burnett,109 the claimant, an employee of the Elbert County Sheriff’s Department, was injured while breaking up a fight between two individuals. He subsequently left the sheriff’s department, and filed a claim for workers’ compensation benefits maintaining that he suffered organic brain damage. In support of his claim, Burnett presented the testimony of several experts. In defending the claim, the employer submitted expert testimony from one clinical neuropsychologist. After reviewing medical records, reviewing tests, and interviewing the employee for approximately two hours, the neuropsychologist opined that the employee’s problems were not caused by the work accident.110 The Board denied benefits, but the superior court reversed. The court of appeals held this was error, noting that the Board had authority to disregard a “whole college of physicians.”111 Because there was evidence to support the denial of benefits, albeit only one expert as opposed to the four opinions presented by the employee, the superior court was without authority to reverse.112

Medical opinions and the “any evidence” rule came into play in SMB Stage Line, Inc. v. Leach.113 Leach filed a claim for workers’ compensation benefits, which was initially denied by the Administrative Law Judge (“ALJ”) on the grounds that her injury resulted from a congenital condition as opposed to a work-related accident. The denial was based on medical reports submitted by the parties. The full Board reversed, awarding benefits based on a finding that although Leach suffered from a pre-existing condition, it was aggravated by work. The superior court affirmed the finding of an aggravation, but remanded the case, directing the full Board to apportion the benefits to eliminate those expenses that were attributable to the congenital condition.114 The court of appeals reversed.115 The court reinstated the decision of the full Board and held that there was no requirement for apportionment under the Act unless

110. Id. at 379-81, 408 S.E.2d at 169-70.
111. Id. at 382, 408 S.E.2d at 171 (quoting B.F. Goodrich Co. v. Arnold, 88 Ga. App. 64, 70, 76 S.E.2d 20, 23 (1953)).
112. Id.
114. Id. at 229, 418 S.E.2d at 792.
115. Id. at 231, 418 S.E.2d at 794.
the claim involved an occupational disease. If a work injury aggravates a pre-existing congenital condition, then it is fully compensable as a new accident.

The question of weight and credit given to evidence, including testimony of witnesses, is a proper one for the Board as the trier of fact. This principle was confirmed in at least three decisions during the survey period. In McLeroy Plumbing Service, Inc. v. Starks, the court of appeals affirmed an award of benefits, noting that although the claimant's testimony may have been impeached at the hearing, it was supported by unimpeached testimony from the treating physician. Thus, there was competent evidence to support the award of benefits to the employee. In Sunbelt Specialties v. Keith, the Superior Court of Camden County remanded a case to the Board for consideration of an issue that it believed the ALJ had overlooked. The court of appeals disagreed, holding that this was not the case, and that the ALJ had denied benefits based on the employee's lack of credibility and the inadequacy of his own medical evidence. The denial of benefits was upheld.

In Gasses v. Professional Plumbing Co., the court of appeals held that an award of benefits is proper even though it was supported only by the employee's self-serving statements. In Gasses the superior court reversed the award of benefits apparently based on a finding that the employee's testimony was outweighed by the opinions of three physicians who felt he could work without restrictions. As noted above, and although it might seem illogical, the Board may ignore "a whole college of physicians" when awarding or denying benefits. In Conwood Corp. v. Guinn, the court of appeals considered the issue of whether there was any evidence to support the finding that the principle location of an employment relationship was in Georgia. Pointing to the record, the court of appeals held that there was such evidence, specifi-

116. Id.
117. Id.
120. Id. at 272, 410 S.E.2d at 758.
122. Id. at 167, 410 S.E.2d at 364.
123. Id. at 168, 410 S.E.2d at 365.
124. Id.
126. Id. at 70-71, 418 S.E.2d at 425-26.
cally the employee's own testimony, and affirmed the decisions of the Board and superior court.129

B. Arising Out of and in Course of Employment

The most interesting decision in the "arising out of and in the course of employment" section130 came in Goode Bros. Poultry Co. v. Kin.131 Kin, an employee of Goode Brothers, died suddenly and unexpectedly during his normal working hours. No signed death certificate was issued, nor was an autopsy performed. Kin's dependents filed a claim for benefits, arguing that because the death was unexplained, they were entitled to the presumption that it arose out of and in the course of employment. The employer countered with medical testimony to the effect that Kin died from a pre-existing heart condition, which not only explained the cause of death, but which also purportedly showed that it was not attributable to his employment.132 Despite the lack of a death certificate or autopsy, the ALJ found that the death was unexplained, thus rejecting the employer's medical evidence that Kin died from a heart attack.133 If the employer had been successful, then it would have had the burden of overcoming the natural inference [that] the death was work-related if the evidence shows the work engaged in by the employee was sufficiently strenuous or of such a nature that, combined with other facts of the case as to raise such a natural inference through human experience that the exertion contributed toward the precipitation of the heart attack.134

Because the employer failed to rebut the presumption of the unexplained death, there was no need to delve into the possibility of a heart attack, and the award of benefits was affirmed.135

Two cases during this survey period concerned assaults on employees. In Williams v. Atlanta Family Restaurants, Inc.,136 the claimant traveled "to Commerce, Georgia to assist in the training of waitresses for a new Shoney's restaurant."137 While in Commerce, she and several other members of the training staff were housed at the Econo Lodge motel, and the supervisory personnel stayed at a nearby Holiday Inn, which had laundry

129. Id. at 44-45, 410 S.E.2d at 316.
132. Id. at 557-58, 411 S.E.2d at 724.
133. Id. at 558, 411 S.E.2d at 725.
135. Id. at 558-59, 411 S.E.2d at 726.
137. Id. at 344, 419 S.E.2d at 328.
facilities. One evening, Williams and another employee went to the Holiday Inn to do their laundry. While waiting for it to finish, they went to the lounge to eat and have drinks. At approximately 11:00 p.m., Williams' roommate informed her that the laundry was finished and that she was returning to the Econo Lodge. Williams decided to stay at the lounge to socialize. Later that evening, she rejected an offer by her supervisor to take her back to the Econo Lodge. Instead, she left the Holiday Inn at approximately midnight with a woman and three men that she had met that evening. Unfortunately, she was attacked shortly thereafter, which led to the filing of this workers' compensation claim.

The ALJ denied the claim after finding that Williams "'stepped aside from her job'" when she refused the offer of a ride back to the Econo Lodge from her supervisors and remained in the lounge. Both the full Board and the superior court affirmed. The court of appeals also affirmed the ALJ's decision. The court contrasted a 1972 decision, McDonald v. State Highway Department, in which the employee, who was staying at a hotel while working out of town, injured himself when he fell down a flight of stairs. Even though McDonald had consumed alcohol prior to the fall, the court affirmed his award of benefits based on a finding that he had conducted himself in a "'normal and prudent manner.'" The court of appeals then focused on Williams' conduct, holding that when she rejected offers for a ride back to the Econo Lodge by her employer, choosing instead to leave with strangers, she was no longer in the course of her employment.

In the second assault case, Maxwell v. Hospital Authority of Dade, Walker & Catoosa Counties, the employee opted for filing a tort claim against her employer. Just after completing her shift in the early morning hours of May 6, 1990, Maxwell was robbed, raped, and beaten in the employee parking lot. Although she conceded that her injuries arose in the course of her employment, Maxwell filed a tort claim, arguing that the injuries did not "arise out of" her employment and, therefore, the exclusive remedy provisions of the Act did not bar her suit. The basis of her claim was that her attacker obviously singled her out due to her dress and jewelry, and because the assault was "personal" in nature, she should be

138. Id.
139. Id., 419 S.E.2d at 328-29.
140. Id., 419 S.E.2d at 329.
141. Id. (quoting the ALJ order).
142. Id. at 343-44, 419 S.E.2d at 328.
143. Id. at 346, 419 S.E.2d at 330.
145. Id. at 176, 192 S.E.2d at 923.
146. 204 Ga. App. at 345, 419 S.E.2d at 330.
able to proceed in tort. The superior court disagreed, granting her employer summary judgment. After reviewing the record, the court of appeals affirmed, rejecting Ms. Maxwell’s argument that the assault was purely personal, and held that her “employment did not merely provide the time and place for the assault upon her, but that the same increased the risk of the attack, and subjected her to a danger peculiar to the employment.” The fact that the attacker knew how Maxwell normally dressed at work and the type of jewelry she wore “highlighted” the fact that his knowledge of her was connected with the workplace. Maxwell’s tort claim was barred because her injury “arose out of, and in the course of” her employment.

In Tate v. Bruno’s, Inc./Food Max, the court of appeals considered the compensability of a parking lot accident. On October 16, 1989, Tate completed her shift, clocked-out, and walked directly from her employer’s store to her car in a parking lot that was used both by patrons and employees. After letting her car warm up for a few minutes, Tate was backing up when a truck struck her vehicle. The record showed that approximately ten minutes had elapsed between her clocking-out and the time of the accident. In its opinion, the court of appeals initially stated that the general rule was that accidents sustained while going to or from work were not compensable. However, the court noted that an employee’s period of employment also included a “reasonable time for ingress to and egress from the place of work, while on the employer’s premises.” In this case, the accident “occurred in a public parking lot which was neither owned, controlled, nor maintained by the employer.” Thus, the court affirmed the denial of benefits even though the parking lot was adjacent to the employer’s place of business and was the location at which the employee’s parked their automobiles. That the employer may not own or maintain the lot should not end the inquiry since “control” by the employer would suffice. Unfortunately, this decision was silent as to whether the employee made any inquiry into the possibility of whether

148. Id. at 92-95, 413 S.E.2d at 205-07.
149. Id. at 92, 413 S.E.2d at 205.
150. Id. at 95, 413 S.E.2d at 207 (quoting Employers Ins. Co. of Ala. v. Wright, 108 Ga. App. 380, 383, 133 S.E.2d 39, 41 (1963)).
151. Id. at 92, 413 S.E.2d at 207.
153. Id. at 396, 408 S.E.2d at 457.
154. Id.
155. Id. (quoting Knight-Ridder Newspaper v. Desselle, 176 Ga. App. 174, 175, 335 S.E.2d 458, 459 (1985)).
156. Id. at 397, 408 S.E.2d at 458.
157. Id.
158. Id.
the employer had any control over this particular parking lot by way of a lease or other agreement with the owner of the shopping center. Indeed, because this apparently was the only lot in which the employees could park, it is difficult to square this decision with the multitude of cases requiring a liberal construction of the Act to effectuate its humane objectives.\footnote{159. See, e.g., Brannon v. Georgia Bureau of Investigation, 146 Ga. App. 524, 246 S.E.2d 511 (1978). There is authority in other jurisdictions that, if applied to these facts, may have allowed Tate to recover. Livingstone v. Abraham & Straus, Inc., 524 A.2d 876 (N.J. Super. Ct. App. Div. 1987), aff’d, 543 A.2d 45 (N.J. 1988); 1 Arthur Larson, The Law of Workers’ Compensation § 15.42(a) (1992).}

Although independent contractors may have “ill-defined parameters of employment,” they must nevertheless show that their injuries resulted from an accident arising out of and in the course of their employment in order to obtain workers’ compensation benefits.\footnote{160. Winn Express Co. v. Hall, 202 Ga. App. 45, 47, 413 S.E.2d 505, 507 (1991).} In Winn Express Co. v. Hall, the claimant, a truck driver, was undisputably an independent contractor, but was nevertheless covered by his employer’s workers’ compensation policy pursuant to O.C.G.A. section 34-9-124. Although the claimant usually commenced his workday by picking up his truck, which he owned, at his employer’s terminal, and completed his workday by returning to the terminal at the end of the day, on occasion, he was permitted to drive the truck home so that he could begin the next day’s work from that location. His employer allowed him to go home without returning to the terminal if it was more convenient so long as he sent his paperwork in through another driver before the end of the day. The starting or ending point had no effect on his income since the claimant’s employer paid a percentage of the customer’s fee for hauling the load. Hall had purchased his own insurance to cover the truck for those occasions on which he was not driving for his employer.\footnote{161. 202 Ga. App. 45, 413 S.E.2d 505 (1991).}

On the day of the accident, Hall drove the truck to and from work because his personal vehicle had broken down. Hall testified that he was “usually told” to call the dispatcher before 5:00 p.m., but he could not remember whether he did so on that date. Within a couple of blocks from his last delivery, at about 2:30 p.m., Hall was involved in an accident that caused injuries to his lower back and right leg. In addition to receiving benefits from his personal insurance policy, Hall filed a claim for workers’ compensation benefits.\footnote{162. Id. at 45-46, 413 S.E.2d at 506.} The Board denied the claim on the grounds that the “injuries did not arise out of his employment because he was on his way home in his own vehicle, was not paid for his transportation and

\footnote{163. Id. at 46, 413 S.E.2d at 506.}
was not performing any activity for the employer while en route to or from his home.\textsuperscript{164} After determining that Corbin v. Liberty Mutual Insurance Co.\textsuperscript{165} did not govern this case, the superior court reversed, noting that not only was Hall permitted to begin and end his workday from home, but when the accident occurred he still was on call, even though there was no further assignment for him at that time.\textsuperscript{166} The court of appeals reversed, pointing to the Board's finding of fact that Hall was not under the direction and control of the employer at the time of the accident because there was no further work for him that day.\textsuperscript{167} Even though Hall was an independent contractor, he was not removed from the general rule that injuries sustained while going to or from work are not compensable. There was no evidence to show that Hall was on call or that he was requested or permitted to drive the truck to his home for the mutual benefit of both parties. On this day, Hall had not been given any further assignments, which he could have refused, and he was driving the truck home not because of a destination on the following morning, but because he was without the use of his own personal vehicle.\textsuperscript{168}

C. Attorney Fees

The choice of insurance carrier was an unfortunate one for the employer in Claxton Manufacturing Co. v. Hodges.\textsuperscript{169} On the date the claimant was injured, Claxton was insured by American Mutual Liability Insurance Company. Because the carrier had processed the claim in an untimely manner, the Board assessed attorney fees pursuant to O.C.G.A. section 34-9-108. American Mutual became insolvent approximately two years later, and the Georgia Insurers Insolvency Pool ("GIIP") resumed payment of the disability benefits. However, because GIIP was not responsible for attorney fees as a matter of law,\textsuperscript{170} the carrier discontinued these payments. The employee subsequently filed a claim against his former employer seeking payment of the attorney fees. Since the Board assessed the fees against the employer/insurer in the original award, the Board ordered Claxton to continue to pay these amounts although the assessment may have been made because of its former insurer's conduct.\textsuperscript{171} The court of appeals affirmed.\textsuperscript{172}

\begin{itemize}
  \item \textsuperscript{164} Id. at 46, 413 S.E.2d at 506.
  \item \textsuperscript{165} 117 Ga. App. 823, 162 S.E.2d 226 (1968).
  \item \textsuperscript{166} 202 Ga. App. at 46, 413 S.E.2d at 506.
  \item \textsuperscript{167} Id. at 47, 413 S.E.2d at 507.
  \item \textsuperscript{168} Id.
  \item \textsuperscript{170} O.C.G.A. § 33-36-3(2)(G) (1992).
  \item \textsuperscript{171} 201 Ga. App. at 371-72, 411 S.E.2d at 110.
  \item \textsuperscript{172} Id. at 372, 411 S.E.2d at 110.
\end{itemize}
However, in *Goode Bros. Poultry Co. v. Kin*, the court reversed the assessment of attorney fees. The award had been based on findings by the ALJ that defendant proceeded on unreasonable grounds and "'[that the] claim was controverted by [the employer/insurer], pursuant to O.C.G.A. section 34-9-221(d), prior to conducting any reasonable investigation.'" The court rejected both of these findings, holding that although the award of compensation might have been authorized by the Board, it certainly was not demanded. Not only had the employer/insurer made a reasonable attempt to convince the ALJ that the presumption of an unexplained death was inapplicable, but the court pointed out that O.C.G.A. section 34-9-221 does not require a "reasonable investigation" before filing a notice to controvert. This section only requires that a party give notice, and that the notice specify the "'ground upon which the right to compensate is controverted.'"

D. Average Weekly Wage

In *Atlanta Journal & Constitution v. Sims*, the court of appeals considered whether mileage expenses should be considered income for use in the average weekly wage computation. In his decision, the ALJ relied upon Board Rule 260, which provides that "'[c]omputation of wages shall include, in addition to salary, hourly pay, or tips, the reasonable value of food, housing, and other benefits furnished by the employer without charge to the employee which are listed as earned income on employee's Federal Form W-2 for federal income tax purposes.'" The ALJ held against the employee on the grounds that because she did not include the mileage reimbursement in her taxable income, it should not be included in the average weekly wage. The superior court had difficulty with the ALJ's use of the term "taxable income" when the rule itself referred to "earned income." Thus, it remanded the case for an interpretation, which led to this appeal.

Although Board Rule 260(a) clearly was written to include "the reasonable value of food, housing, and other benefits furnished by the employer..."
without charge to the employee” only if listed on a Form W-2 for federal income tax purposes, the court of appeals sided with the superior court and found that there was an ambiguity. Apparently, this resulted from the court of appeals’ inability to find a definition for “earned income” in the Internal Revenue Code. After stating as much, the court discussed certain rules of construction and prior decisions on average weekly wage, ultimately holding that the employee would be entitled to any portion of the mileage payments that might constitute real economic gain to her. In other words, the employee would be entitled to any amount above and beyond the actual expense she incurred by using her own automobile during the course of her employment. The decision may be just, but it overlooks the Board’s authorization by law to “make rules, not inconsistent with this chapter, for carrying out this chapter.” If the court concluded that Board Rule 260 was not consistent with the Act, then it should have stated so rather than searching for an ambiguity that, on the face of the rule, does not appear to be present. Because it is very difficult for both sides to establish an average weekly wage, especially when trying to ascertain a value on “other benefits,” the Board promulgated this rule to ease the burden by requiring that items other than salary, hourly pay, or tips be included on the Form W-2. Unfortunately, this case revives the very problems that the rule sought to cure.

In a subsequent decision, Pizza Hut Delivery v. Blackwell, a case concerning whether tips should be included, the court of appeals seems to have confirmed that Board Rule 260(a) is not ambiguous. In Pizza Hut Delivery, the employer convinced the ALJ to exclude tips from the average weekly wage computation so that they were not listed as earned income on the employee’s Form W-2. The full Board disagreed, adding the tips to the average weekly wage. The superior court affirmed, and on appeal the court of appeals pointed out that “tip” income is found in a separate section of the rule, and is not required to be listed on the Form W-2. Furthermore, as pointed out by the court, tips have long been held to be included in the average weekly wage computation. Although the court found Board Rule 260(a) to be unambiguous in this case, it nevertheless felt compelled to support its earlier decision in Sims, stating

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182. GA. BD. OF WORKERS’ COMPENSATION R. 206 (O.C.G.A. tit. 34 (1992)).
187. GA. BD. OF WORKERS’ COMPENSATION R. 260 (O.C.G.A. tit. 34 (1992)).
189. Id. at 113, 418 S.E.2d at 640.
190. Id. at 112, 418 S.E.2d at 640.
that it would interpret tips to be reported on the Form W-2 and that even if the employee failed to do so, the court would not estop an employee from including tips in the computation of his average weekly wage.\footnote{191} This statement is superfluous in that it fails to add anything to the opinion when Board Rule 260(a) has never required an employee to list tips on the Form W-2 in order to use them in the computation of average weekly wage.\footnote{192}

\section*{E. Change in Condition}

Under Georgia law, it is well-settled that when an employee suffers an on-the-job injury, returns to gainful employment, and subsequently seeks the recommencement of temporary total disability benefits, the burden of proof is on the employee to "show that his inability to secure suitable employment elsewhere was proximately caused by his previous accidental injury."\footnote{193} The court of appeals revisited this issue in \textit{Aden's Minit Market v. Landon}\footnote{194} and emphasized the necessity for strict adherence to this evidentiary principle.

Landon, the claimant, was injured while working for Aden's. Her employer paid temporary total disability benefits, which were subsequently stopped, and then partial disability benefits, which started because she returned to full-time employment. Her subsequent employer terminated her on the basis of misconduct, since she was illegally receiving total disability benefits under the Act while working. The Board awarded the recommencement of total disability benefits upon her termination and the superior court affirmed.\footnote{195}

The court of appeals reversed the award of benefits on the finding that the claimant had not met her burden.\footnote{196} "We cannot presume that Landon was not hired because of her disability . . . . An employee is not entitled to resumption of total disability payments merely because she was terminated from subsequent employment."\footnote{197}

In acknowledging the well-settled principle that the claimant must carry the burden of showing that the inability to secure suitable employment elsewhere is proximately caused by the previous accidental injury, the court noted that the claimant's testimony that she had sought employment elsewhere was insufficient, standing alone, since "the record

\footnotesize{\begin{itemize}
\item 191. \textit{Id.} at 113, 418 S.E.2d at 640.
\item 192. \textit{Ga. Bd. of Workers' Compensation R.} 206 (O.C.G.A. tit. 34 (1992)).
\item 195. \textit{Id.} at 219, 413 S.E.2d at 739.
\item 196. \textit{Id.} at 220-21, 413 S.E.2d at 740.
\item 197. \textit{Id.} at 220, 413 S.E.2d at 740.
\end{itemize}}
[was] silent on the reasons why she was not hired by any of these other employers." Consequently, when the evidence establishes that a claimant is capable of performing some form of gainful employment and is not totally disabled, the claimant must show not only that reasonable efforts have been made to secure suitable employment, but also that these efforts have not been successful because of the physical impairment from the previous on-the-job injury.

F. Coverage and Jurisdiction

Although not frequently seen at the State Board, coverage questions do arise on occasion. In Travelers Insurance Co. v. Adkins, the court of appeals considered a coverage question that required examination of the parties' past conduct. Adkins sustained a work-related injury while in the employ of Labor Services, Inc. ("LSI") on July 15, 1988. The insurance carrier, Travelers, controverted the claim because LSI's policy had been cancelled on May 1, 1988. The Board found against Travelers, and the court of appeals affirmed, holding that during their relationship, LSI and Travelers had established a course of conduct whereby the insurer would cancel the employer's coverage for non-payment of premiums, but would reinstate coverage retroactively upon receipt of the payment. This cancellation and reinstatement of coverage went on for a period in excess of one year, and in fact occurred just prior to Adkins' injury. Furthermore, and perhaps more importantly, not only had Travelers mailed LSI a premium notice on the third policy, the one which was to be in effect at the time of Adkins' injury, but LSI made payment of same, which was accepted by Travelers prior to the accident. The fact that Travelers may have cancelled properly under the applicable insurance Code section and also filed written notice of cancellation with the State Board failed to persuade the court of appeals to reverse. The court noted the following:

While Board rules requiring documentation of certain matters with the NCCI [National Council on Compensation Insurance] do require additional action on the part of a workers' compensation insurance carrier, we do not find, nor has appellant cited, any reason why Board Rule 126 should distinguish workers' compensation insurance law from principles applicable to insurance law in general. Therefore, contrary to appellant's argument, we do not agree that cancellation in compliance with O.C.G.A.

198. Id., 413 S.E.2d at 739.
201. Id. at 278, 407 S.E.2d at 776.
202. Id. at 280-81, 407 S.E.2d at 777-78.
203. Id. at 280, 407 S.E.2d at 778.
§ 33-24-44(b) and Board Rule 126, regardless of other circumstances surrounding the cancellation, automatically entitles a workers’ compensation insurer to complete relief against a claim that the cancellation was not effective or applicable.204

Travelers was involved in yet another coverage question case during the survey period, but this time enjoyed success.205 Travelers was the insurance carrier for Winkler Sign Company, a Tennessee employer. Winkler came to Georgia to erect a sign for Granny’s of Atlanta. In doing so, one of its employees suffered catastrophic injuries. The employee not only successfully applied for workers’ compensation benefits in Tennessee, but he filed a tort claim against several defendants, including Granny’s, which netted him $360,000. Under Tennessee law, Travelers exercised its right to subrogation and recovered $80,000 of the tort settlement. Thereafter, the employee filed for workers’ compensation benefits in Georgia against Winkler with Travelers as the workers’ compensation carrier, and Granny’s of Atlanta, Inc., as a statutory employer.206

The ALJ ruled that Travelers was responsible for payment of Georgia workers’ compensation income benefits, but was entitled to a credit against any amounts paid under Tennessee law. The full Board affirmed the award of the ALJ, but disallowed the credit on the grounds that at the time of the accident, Georgia did not recognize subrogation.207 The superior court affirmed, but the court of appeals reversed, holding that there was no evidence to support the ALJ’s finding that the policy issued by Travelers to Winkler provided coverage for any benefits payable under Georgia law.208 The court held that under the doctrine of lex loci contractus, Tennessee law permitted the agreement between Winkler and Travelers to limit coverage to benefits payable only under the Tennessee Law.209 According to the court, this would not frustrate the public policy of Georgia and, in fact, was “consonant with general public policy in Georgia.”210 The court of appeals rejected the ALJ’s suggestion that Travelers may have committed fraud or deceit in stating that there was no evidence whatsoever of such conduct in the record.211 As a result, the court dismissed Travelers and allowed the employee to collect Georgia

204. Id. at 281, 407 S.E.2d at 778.
206. Id. at 297-98, 410 S.E.2d at 789-90.
207. Id. at 298, 410 S.E.2d at 790.
208. Id. at 300, 410 S.E.2d at 792.
209. Id. at 300-01, 410 S.E.2d at 790.
210. Id. at 301, 410 S.E.2d at 793.
211. Id. at 302-03, 410 S.E.2d at 793-94.
benefits against Granny’s as his statutory employer under O.C.G.A. section 34-9-8.212

The court of appeals considered whether an employer was estopped to deny that it was subject to the Act in Horne v. Exum.213 The employee suffered an injury while in the course of his employment. Not only did the employer pay the employee his regular weekly salary, but the employer reimbursed the employee for his medical treatment. At a hearing before the Board, the ALJ found that the employer was a partnership that had fewer than three employees, and, therefore, was not subject to the Act. The full Board agreed, but the superior court reversed, holding that the employer “had voluntarily elected to be bound by the Act by paying the employee’s salary and medical expenses and was estopped to deny benefits.”214 The court of appeals disagreed, finding that the doctrine of equitable estoppel did not apply.215 Estoppel is mutual, and because there was no evidence in the record that established that the partnership had ever told the employee or led him to believe that he was covered by workers’ compensation, one could not say that he did or failed to do anything which prejudiced his position. The court noted:

To hold otherwise would not only be unfair to employers who find themselves in Horne’s situation by blindsiding them when they were attempting to do the right thing by an injured employee, but would discourage such employers from making voluntary payments in any case where they were under no legal obligation to do so.216

In Lumber Transport, Inc. v. International Indemnity Co.,217 the court of appeals again reiterated that the Board “is not a court authorized to render judgments on contracts . . . since it merely determines the amount of compensation and the time of payment in accordance with the Act.”218 One of Lumber Transport’s employees, who was injured in Florida, filed a claim in that state. However, because the policy specifically limited coverage to benefits paid under the Georgia Workers’ Compensation Act, International Indemnity made payment under the laws of Georgia in the maximum amount of $155. The company refused to defend the Florida claim, which proceeded to a hearing in which the claimant was awarded $315 per week. International Indemnity thereafter terminated

212. Id. at 303-04, 410 S.E.2d at 794.
214. Id. at 337, 419 S.E.2d at 148.
215. Id. at 338, 419 S.E.2d at 149.
216. Id. at 338-39, 419 S.E.2d at 149.
218. Id. at 589, 417 S.E.2d at 366 (quoting Fireman’s Fund Ins. Co. v. Crowder, 123 Ga. App. 469, 471, 181 S.E.2d 330, 332 (1971)).
payment of benefits to the employee in Georgia, and Lumber Transport commenced payment of benefits under Florida law.\textsuperscript{219}

Lumber Transport filed suit against International Indemnity in the Superior Court of Dekalb County seeking reimbursement for the Florida benefits. Despite International Indemnity's protestations, the superior court asserted jurisdiction on the grounds that this was a contract dispute, not a workers' compensation matter, and eventually rendered summary judgment in favor of International Indemnity, holding that it was not obligated to pay benefits under Florida law because of the policy limitation.\textsuperscript{220} In an eight to one decision, the court of appeals agreed, and affirmed the decision.\textsuperscript{221} If the matter concerned the amount of payment under Georgia law, or the timeliness of same, then jurisdiction would have rested with the Board. However, in this case, even though the carrier had voluntarily paid benefits under Georgia law, no party had ever filed a claim in Georgia.

G. Dependency

In addition to involving issues of whether the accident arose out of and in the course of employment, and assessed attorney fees, \textit{Goode Bros. Poultry Co. v. Kin}\textsuperscript{222} presented a third issue, a claim for benefits as a dependent by the surviving spouse pursuant to O.C.G.A. section 34-9-13(b)(1). Both the ALJ and the full Board found that Mrs. Kin was totally dependent, as opposed to partial.\textsuperscript{223} The superior court had affirmed this finding, but the court of appeals reversed after a close examination of the pertinent statute.\textsuperscript{224} According to the court, "if the surviving spouse was employed for a period of 90 days next prior to the accident which resulted in the death of the deceased employee, the presumption of total dependence shall be rebuttable . . . ."\textsuperscript{225} It was undisputed that Mrs. Kin was in fact employed during the ninety day period prior to her husband's death. Thus, she was not entitled to the conclusive presumption. Because the evidence showed that she was employed full-time, and that she and her adult children "made regular and substantial contributions toward payment of the household expenses," there only could be a finding

\textsuperscript{219} \textit{Id.} at 558, 417 S.E.2d at 366.
\textsuperscript{220} \textit{Id.} at 589, 417 S.E.2d at 366.
\textsuperscript{221} \textit{Id.} at 588, 417 S.E.2d at 365.
\textsuperscript{223} \textit{Id.} at 559, 411 S.E.2d at 726.
\textsuperscript{224} \textit{Id.} at 557, 411 S.E.2d at 728.
\textsuperscript{225} \textit{Id.} (quoting O.C.G.A. § 34-9-13(b)(11) (1992) (emphasis supplied by court)).
of partial dependency. The court reversed the case on this issue and remanded to the full Board for entry of a new award.

H. Exclusive Remedy

The exclusive remedy provision of the Act provides that if employees suffer a compensable work-related injury, their rights and remedies are limited to those found in the Act. However, because of the limited benefits available under the Act, particularly no punitive damages, parties continue to file tort claims, often using creative allegations in an attempt to avoid coverage. The case of Bryant v. Wal-Mart Stores, Inc. sets forth a good example. Bryant, an employee on Wal-Mart’s night crew, was locked in the store for security reasons. She suffered a stroke, and because emergency medical personnel were unable to reach her in time, she died. The administrator of her estate filed a tort claim alleging, among other things, that not only was the injury caused by wilful and intentional conduct, false imprisonment, but that the employer was guilty of Racketeer Influenced and Corrupt Organizations (“RICO”) violations under O.C.G.A. section 16-4-4(a). Both the superior court and the court of appeals rejected these contentions, noting once again that the Act precluded recovery “for wilful or intentional acts of the employer so long as the injury arises out of and in the course of employment.” The Act precluded recovery in this case because it was undisputed that Bryant was locked in the store for business purposes, that she was engaged in the performance of her work duties at the time she suffered the stroke and that the emergency crew was unable to render immediate assistance to the deceased due to the delay in gaining entrance to the store.

With regard to the allegation that the employer was guilty of a RICO violation, the court found that there was nothing in the language of this statute or the Act to suggest that the legislature intended such a violation to supersede the exclusive remedy provision.

Not only does the exclusive remedy provision protect the employer from a tort action by its employees, but it may protect the employer from third party lawsuits as well. This is exactly what occurred in Georgia De-
A Campbell employee suffered radiation burns while using a fluoroscopic machine. She received workers' compensation benefits from her employer, and later sued the Department of Human Resources ("DHR") and its inspector for negligent inspection. DHR filed a third party complaint against Campbell, alleging that its intentional violation of state regulations entitled DHR to contribution and indemnity. The Superior Court of Gwinnett County held that Campbell was immune from liability because of its payment of workers' compensation benefits to Gibson. On appeal, DHR argued that the exclusive remedy provision should not apply in those instances in which a "passive tortfeasor has a claim for implied indemnity against an employer whose active negligence primarily caused the employee's injuries." The court of appeals rejected this argument, agreeing with the superior court that Campbell was immune from liability after having paid workers' compensation benefits. The court refused to permit DHR's claim of implied indemnity as a joint tortfeasor, holding that when the relation between the parties does not spring from a contract or special position such as a bailee or lessee, the third party cannot recover indemnity from the employer, since an active or primary wrongdoer does not have an implied obligation, capable of penetrating the exclusiveness rule of workmen's compensation law, to indemnify a passive or secondary tortfeasor.

However, the court was quick to point out that the Act did not prevent a defendant from seeking indemnification based on a contract. Once again, in Sargent v. Blankmann, the court of appeals held that when the accident arises out of and in the course of employment, the exclusive remedy provision bars tort actions between co-employees. On September 26, 1988, Sargent and Bohan, both employees of the Georgia Department of Human Resources, left Atlanta to attend to a work-related meeting in Dahlonega, Georgia. On the way to the meeting they were in an automobile accident in which Bohan suffered fatal injuries. Bohan's children thereafter filed a tort claim against Sargent, which the court determined was barred by the exclusive remedy provision.
I. Indemnity Benefits

In Liberty National Life Insurance Co. v. Coley, the issue was whether the employee had received timely payment of a settlement in the amount of $125,000. The settlement had been approved by the Board on December 5, 1989. At that time, Georgia law required that the claimant actually receive payment within twenty days. On December 21, the third-party administrator for payment of the benefits mailed two settlement checks by United Parcel Service Next Day Air to Liberty’s attorney in Savannah, Georgia for forwarding to the employee’s attorney in St. Mary’s, Georgia. Liberty’s attorneys personally delivered the checks to a Federal Express office, and Federal Express personnel assured them that they would deliver the letters to the employee’s attorney the following day, Saturday, December 23, 1989. Liberty’s attorneys used express mail because of an approaching winter storm. Unfortunately, this method proved ineffective because the roads to St. Mary’s had been closed.

The employee finally received the checks on December 26 at approximately 4:06 p.m., which was considered the twentieth day because of the holiday the day before. Nevertheless, the employee filed for a hearing with the Board seeking an additional $25,000, arguing that she received the checks so late in the day that she was unable to negotiate them and, therefore, was entitled to a statutory penalty. The Board agreed with the employee and assessed a $25,000 penalty. However, the court of appeals reversed, noting that although there was precedent requiring that an employee receive benefits within twenty days of an award, there was “no express or implied determination that receipt of negotiable instruments, which [was] an acceptable method of payment,” was not effective until actual negotiation. According to the court, “[r]equiring the payor to calculate into the 20 day payment period such factors as weather prognosis, banking hours and regulations, and the claimant’s or attorney’s cooperation in negotiating the instruments within the allocated time frame, defies reason and equity and effectively shortens the period the statute specifies.” It is ironic that the employer was forced to litigate the matter all the way to the court of appeals to obtain this decision.

In Transus, Inc. v. Fleck, the court of appeals considered an employee’s ability to recoup an advance. Fleck, who was injured in 1985,
received a total of $15,000 in two separate advances, the first occurring on June 10, 1987, and the second occurring December 9, 1987. Both awards permitted the employer to take credit against payment of permanent partial disability benefits that might become due at a later date under O.C.G.A. section 34-9-263. In 1988, the employer became aware that Fleck was permanently and totally disabled and, thus, no permanent partial disability rating would be assessed. The employer then moved for reduction of Fleck’s weekly benefits in order to recoup the advances.¹⁵⁰

After a hearing in which most of the evidence was submitted by stipulation, the ALJ ordered the carrier to reduce income benefits by $50 per week. On de novo review, the full Board decided that since the employee did not appeal the awards of June 10, 1987 or December 9, 1987, the employer's ability to take credit would be limited to any permanent partial disability benefits that might become due.¹⁵¹ Thus, the full Board reversed the ALJ’s decision on the grounds that the prior awards were res judicata with respect to the method of repayment.¹⁵² The court of appeals reversed, holding that there was no evidence that the question of Fleck's permanent total disability could have been addressed at the time of the advances.¹⁵³ The language in the awards that the employer could take credit by reducing permanent partial disability merely reflected an “anticipated” means of repayment. The court held this would not be a substantive bar to recoupment if the anticipated permanent partial disability status did not materialize, and to “conclude otherwise would work an injustice on the employer/self-insurer who has provided additional assistance to claimant by virtue of the advances.”¹⁵⁴

When a settlement agreement designates beneficiaries in the event of the death of the employee, the courts do not consider the monies to be part of the estate, and the estate shall pay the beneficiaries with no deduction for year’s support.¹⁵⁵ In King v. Travelers Insurance Co.,¹⁵⁶ the employee was to receive $850 per month for life, guaranteed for sixteen years. If he died within sixteen years, the remaining monthly payments were payable to his designated beneficiaries. Upon the employee's death, which came well within the sixteen year period, his common law wife applied for year's support through the probate court, which the court granted. She then sought to enforce the order in the superior court, but

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²⁵⁰ Id. at 306, 418 S.E.2d at 817-18.
²⁵¹ Id., 418 S.E.2d at 818.
²⁵² Id.
²⁵³ Id. at 307, 418 S.E.2d at 818-19.
²⁵⁴ Id. at 308, 418 S.E.2d at 819. The court also questioned whether it was procedurally proper for the Board to consult its own files, which were not in evidence. Id.
that court dismissed the suit upon the insurance carrier’s motion. The court of appeals agreed, likening the monthly payments under the settlement to proceeds of a life insurance policy that vest in the named beneficiary and, therefore, are not part of the decedent’s estate, which is subject to year’s support.

J. Medical Benefits

If practitioners have taken anything for granted over the years in the workers’ compensation area, it is that once physicians become authorized, then they may automatically authorize a subsequent physician by making a referral. Two decisions during the survey period prove that this may not have been the case after all. In Brown v. Transamerica IMS, the employee was referred to a psychologist by his authorized treating physician. The employer apparently did not like this medical provider, and instead chose another psychologist who was treating his mother-in-law. The original physician then referred Brown to the second psychologist, but within a month told him that he was revoking the referral and would be sending him to a third psychologist. The employer/insurer, having initially paid for the second psychologist’s visits, filed a notice to controvert as of the date of the revocation.

The ALJ sided with the employer, finding that the employer was not responsible for the unpaid medical bills of the second psychologist on two grounds. First, the basis for the referral originated with the employee himself, and second, the authorized treating physician had revoked it. The full Board affirmed. On appeal, the superior court rejected the ALJ’s reasoning that the referral was invalid because it originated with the employee, but sided with the ALJ, holding that the authorized physician had the authority to revoke the referral if based on “sound and reasonable discretion of the employer-selected physician.” The court remanded the case for determination of the reason for the revocation, which led to this appeal.

The court of appeals, in an interesting opinion, held that under a prior decision from the Georgia Supreme Court construing O.C.G.A. section 34-9-201, “only parties who change physicians and/or treatment with Board approval have their respective interests protected under the Workers’
This was the case despite the fact that O.C.G.A. section 34-9-201(c) provides in part that "[t]he physicians selected under this subsection may arrange for any consultation, referral, and extraordinary or other specialized medical services as the nature of the injury shall require." However, because the employer had paid a portion of the fees generated by the second psychologist, the court determined that the employer had acquiesced and, therefore, could not controvert his treatment as being unauthorized.

In a later case, *Lee Fabricators v. Cook*, the court of appeals expounded on its earlier decision as set forth in *Brown*. Cook, an employee of Lee Fabricators, injured her lower back. An employer-provided physician, Dr. Watts, treated her and then, at the request of the employee, referred her to another physician, Dr. Powell. Dr. Powell thereafter referred Cook for psychological and psychiatric treatment, which included hospitalization. Lee Fabricators controverted payment for the psychiatric treatment.

The ALJ awarded payment for prior psychiatric care, including a diet program, but denied payment for future psychiatric treatment because it would be duplicative. The full Board affirmed the ALJ’s award in part, but denied payment for the diet program. The superior court, however, reversed the denial of payment for future psychiatric care, holding "that O.C.G.A. § 34-9-200(b) did not authorize the Board to order a unilateral change in treatment." The court of appeals, referring to its recent decision in *Brown*, once again warned that when parties disregard the procedure set forth in O.C.G.A. section 34-9-201(b) through (d), "they assume the risk of acting without Board approval and are bound by the consequence of their actions." Similar to the employer in *Brown*, the employer/insurer acquiesced with regard to Dr. Powell by making payment to him. Thus, he was authorized and entitled to payment. As for the psychiatric care, the Board made no payment and had authorized no change of physicians. Therefore, the ALJ properly denied liability for future psychiatric care.

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264. *Id.* at 275, 407 S.E.2d at 433 (citing Holcombe v. Brown Transport Corp., 253 Ga. 719, 324 S.E.2d 446 (1985)).


266. 200 Ga. App. at 275, 407 S.E.2d at 433.


269. 203 Ga. App. at 450, 417 S.E.2d at 35-36.

270. *Id.*, 417 S.E.2d at 36.

271. *Id.*, 417 S.E.2d at 36.

272. *Id.* at 451, 417 S.E.2d at 36.

273. *Id.* at 451-52, 417 S.E.2d at 36-37.
Realizing that employees would inundate the Board with requests for change of physicians, the Board promulgated a new rule effective July 1, 1992. Board Rule 201(c) now provides that "[a] referral by an authorized treating physician made pursuant to O.C.G.A. § 34-9-201(c) for the specific purpose of consultation, evaluation, testing, or diagnosis in connection with treatment prescribed by the authorized treating physician does not constitute a change of physician or treatment and does not require an order from the Board." Whether the courts will uphold this if attacked on the grounds that it exceeds the Board's authority remains to be seen.

In Owens-Illinois, Inc. v. Champion, the court of appeals again considered the issue of an authorized medical provider, but in the ensuing decision the court made no reference to either Brown or Cook. In Champion the claimant suffered a compensable, on-the-job injury. She received treatment from a physician on the posted panel for physical injuries and was thereafter referred to Dr. Garrett, a psychiatrist, who performed an independent medical evaluation but did not treat. The orthopedic surgeon that had been treating Champion, Dr. Loughlin, could find nothing wrong with her, and dismissed her from treatment. Thereafter, and in June 1987, Champion obtained unapproved treatment from a medical clinic that in turn referred her to a psychologist, Dr. George, who began to see her in April 1988. Dr. George in turn referred her to a psychiatrist, Dr. Cheatham, who Champion initially saw in September 1988. Prior to these referrals, however, and in November 1987, Dr. McCloud, an orthopedist, had seen Champion and was providing ongoing medical treatment.

In January 1989, the employer agreed to pay for all of the prior medical expenses incurred by Champion, including those from the unapproved medical providers, in exchange for her agreement that Dr. McCloud would be the authorized treating physician and that the employer would not be responsible for additional charges by the other medical providers. One month later she ceased working, and on March 7, 1989 she entered Brawner Psychiatric Institute where she remained hospitalized for two months because of depression and suicidal ideations. Despite her earlier agreement, Champion also continued her treatment with Dr. Cheatham.

275. Id. 201(c) (emphasis added).
277. Id. at 737, 417 S.E.2d at 704.
278. Id.
279. Id. at 737-38, 417 S.E.2d at 704.
Champion sought reimbursement for all of her medical expenses incurred through Dr. George, Dr. Cheatham, and Brawner Psychiatric Institute after January 1, 1989. The ALJ denied her claim for reimbursement, finding that although Champion may have been able to seek treatment on her own at one point because of a complete dismissal by the initial authorized treating physician, Dr. Loughlin, she relinquished this right when she agreed that Dr. McCloud would be the authorized physician in January 1989. Not only did the ALJ reject Champion’s claim that she misunderstood that she was authorized to receive treatment from Dr. McCloud, but he also rejected the contention that the psychiatric hospitalization at Brawner constituted an emergency. The superior court reversed in part, finding that the employer “failed in its obligation to provide mental health services” and, therefore, Drs. George and Cheatham were authorized. Additionally, the superior court found that Dr. McCloud had “implicitly” authorized Drs. Cheatham and George, and that “the ALJ erred as a matter of law in finding that the psychiatric hospitalization did not qualify as a medical emergency.”

The court of appeals reversed the superior court and held that there was no evidence in the record of any referral by Dr. McCloud after January 1, 1989. Furthermore, the court of appeals pointed to statements in the record implying that the parties had agreed that the authorized treating physician would be Dr. McCloud. There was no evidence that Dr. McCloud ever discharged Champion and, in fact, she even testified that she failed to go back to him. As for the ALJ’s finding that there was no “emergency,” this was a question of fact, and the superior court was without authority to reverse. Although the holding in Champion can be read consistently with the court’s earlier decisions in Brown and Cook, the decision nevertheless should be taken as a warning to practitioners that if the parties agree on a change of medical providers, they should obtain Board approval.

With medical costs skyrocketing, group carriers and other medical providers are not only attempting to put a cap on expenses but are also trying to find ways to recover costs. The recovery of costs was at issue in Tolleson Lumber Co. v. Kirk. The question before the court was whether a personal injury protection (“PIP”) carrier could seek reimbursement for medical expenses paid to an employee by filing against the

280. Id. at 738, 417 S.E.2d at 704.
281. Id. at 739, 417 S.E.2d at 705.
282. Id.
283. Id.
284. Id.
workers’ compensation carrier.\textsuperscript{286} The court of appeals answered in the affirmative and held that O.C.G.A. section 34-9-206 was not limited to group health carriers.\textsuperscript{287} The section specifically states that it applies not only to group companies, but to any “other health care provider who covers the cost of medical treatment for a person who subsequently files a claim under this chapter.”\textsuperscript{288}

\textbf{K. Misrepresentation}

In \textit{Red Roof Inn v. Lynn},\textsuperscript{289} the court continued the development of the so-called “Rycroft” defense, which has evolved since the supreme court’s decision in \textit{Georgia Electric Co. v. Rycroft}.\textsuperscript{290} In \textit{Lynn} the court found that medical evidence that an individual who previously experienced recurrent back pain is at an increased risk of having the same type of injury was insufficient, by itself, to establish a causal connection between a concealed pre-existing back condition and a subsequent back injury.\textsuperscript{291} The evidence was offered at a medical deposition at which it was further established that the physician was unaware of the specifics of the claimant’s pre-existing back problems, and could not testify whether the claimant’s current condition was even at the same location of the spine as the pre-existing problem.\textsuperscript{292} Under these circumstances, the court determined that the evidence was insufficient to establish the causal connection required by the decision in \textit{Rycroft}.\textsuperscript{293}

Although the case was reversed and remanded on other grounds, the court’s comments on the “Rycroft” issue are significant in that they are the first attempt by a Georgia appellate court to define what constitutes a sufficient causal connection between a misrepresentation in the employment process and a subsequent on-the-job injury. While the facts surrounding the physician’s opinion in this case are somewhat unusual, in that the physician clearly was unaware of the specifics of the claimant’s pre-existing problems, the court seems to indicate that a causal connection would at least require the subsequent injury to be at the same location of the spine as the concealed, pre-existing condition.

\textsuperscript{286} \textit{Id.} at 689, 409 S.E.2d at 261.
\textsuperscript{287} \textit{Id.} at 691, 409 S.E.2d at 262.
\textsuperscript{290} 259 Ga. 155, 378 S.E.2d 111 (1989).
\textsuperscript{291} 203 Ga. App. at 40, 416 S.E.2d at 309.
\textsuperscript{292} \textit{Id.}
\textsuperscript{293} \textit{Id.}
L. Notice

Georgia's appellate courts have always liberally interpreted the notice requirement of O.C.G.A. section 34-9-80, which requires that an injured employee notify the employer of the occurrence of an on-the-job accident within thirty days. This trend continued in Impress Communications, Inc. v. Stanley.

Prior to going to work for Impress Communications in 1987, Stanley had a long history of back problems. She complained openly of back pain while working for Impress. Her job with the company required lifting and emptying five gallon buckets of water. The claimant contended that in January 1989 she began experiencing intense pain in her back. She mentioned to the president of the company that it was a good thing the company was planning to fix a machine she worked on because "her back was about to give out." About one week later, a chiropractor treated the claimant for what the chiropractor described as a gradual onset of lower back pain. When the claimant returned to the chiropractor for subsequent treatment, her husband telephoned her supervisor and stated his wife "needed bed rest and would not report to work for a couple of days." Several days later, the claimant reported to work in a back brace, which both her supervisor and the company president observed. The claimant only worked a few days, and then physicians diagnosed her having a herniated disc, which required surgery. Throughout the progression of her back pain, the claimant never orally, nor in writing, advised her employer that her back problems were in any way related to her job. When she filled out an application for group insurance coverage of her medical bills, the claimant placed a question mark in the space that asked if her injury was work-related, and made a similar response on a physical therapy questionnaire. When the carrier denied her application for group insurance, both her chiropractor and her orthopedic surgeon provided statements that they had no reason to conclude her back problems were work-related. On May 1, 1989, the group carrier informed her employer that the claimant was contending, for the first time, that her injury was work-related.

The Board determined that the claimant's back problems were the result of her work activities over a two year period for Impress Communications. The Board rejected the employer's notice defense on the grounds

296. Id. at 227, 414 S.E.2d at 238.
297. Id., 414 S.E.2d at 239.
298. Id.
299. Id. at 227-28, 414 S.E.2d at 239.
that the claimant’s original statement to the company president regarding
the fixing of her machine was sufficient to constitute “legal notice” under
O.C.G.A. section 34-9-80. The court of appeals affirmed, citing the now
familiar rule that the required notice under O.C.G.A. section 34-9-80 “is
sufficient if it puts the employer on notice of the injury so that it may
make an investigation if it sees fit to do so.” The employer, however,
contended that it did not have a duty to investigate given the claimant’s
repeated assertions throughout her claim for group disability benefits
that her problems were not work-related. The court rejected the em-
ployer’s argument, however, finding that as of the date the claimant
cessated work the employer “had specific knowledge of the toll claimant’s
work was taking on her back.” The court held this was sufficient to
allow the employer to investigate further, if it saw fit to do so. More-
over, the court found that the claimant’s statements that her injury was
not work-related did not preclude recovery because her responses left
open the possibility that the injury might have been job-related.

The court in Stanley goes further than in previous cases interpreting
the notice requirement because it concerned a claimant who made affirm-
itive representations that the alleged injury was not work-related. Given
the court’s sensitivity to barring workers’ compensation benefits on the
technical grounds of notice, employers asserting this defense will have to
do more than merely assert that the claimant did not allege her condition
to be work-related. Employers asserting the notice defense also should
demonstrate that their ability to investigate the case was prejudiced.

M. Procedure

The court of appeals issued a number of significant decisions in the
survey period affecting workers’ compensation procedure, specifically ap-
peals, trial evidence, and the proper form to address setting aside a State
Board decision on the basis of fraud.

Appeals. O.C.G.A. section 34-9-105(b) contains the statutory author-
ity for appealing a decision of the Board to the superior court of the
county in which the injury occurred. In Fasher Painting & Decorating

300. Id. at 228, 414 S.E.2d at 239.
302. Id. at 228-29, 414 S.E.2d at 240.
303. Id. at 229, 414 S.E.2d at 240.
304. Id.
305. Id.
Co. v. Bordelon, the issue presented was whether a party may directly appeal anything other than a final award of compensation benefits to a superior court. In Bordelon the Georgia Insurers Insolvency Pool ("GIIP") made a motion before the ALJ "to add American Policyholders' Insurance Company ("APIC") as a party defendant in regard to hearing 'to determine the proper party for the handling of claimant's workers' compensation benefits.' When the ALJ denied this motion, GIIP appealed, and the full Board reversed, ordering that APIC be added as a party defendant. APIC appealed to the superior court, which reversed.

The court of appeals held that since the full Board's decision to add APIC as a party defendant was not a final decision granting or denying compensation, it was not the proper subject of an appeal to the superior court. The court interpreted O.C.G.A. section 34-9-105(b) to mean that only final awards of compensation may be appealed, as opposed to final orders or judgments dealing with anything other than compensation, such as adding or deleting parties. Addressing appellee's argument that such a ruling would leave the Board free to exceed its statutory authority on such issues, the court of appeals responded that it would not assume that the Board would breach its inherent duty of good faith in applying the law, and further stated that this was a problem for the legislature to address, rather than the courts. Although the court regarded the language of O.C.G.A. section 34-9-105(b) as "unambiguously" prescribing appeals only from a final award of compensation, the statute's wording allows for appeals of any "final award or . . . of any other final order or judgment of the members of the board." The statute is not clear if only final awards providing actual benefits may be appealed, but as the court pointed out, this has been the interpretation placed on the statute previously. Moreover, this interpretation would seem to be consistent with the well-established policy in workers' compensation of promoting swift resolution of workers' compensation disputes. Certainly, the litigation of a workers' compensation case would be slowed if an employee could appeal every order of the Board, whether the order related to compensa-

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308. Id. at 196, 419 S.E.2d at 83.
309. Id.
310. Id.
311. Id.
312. Id. at 197, 419 S.E.2d at 83-84.
313. Id. at 196, 419 S.E.2d at 83.
314. Id. (quoting O.C.G.A. § 34-9-105(b) (1992)).
315. Id. (citing Conwood Corp. v. Guinn, 190 Ga. App. 595, 379 S.E.2d 621 (1991)).
tion benefits or not. Presumably, an employee may include any errors in such decisions in appeals once the Board makes a final award of benefits.

The court more narrowly construed, however, the Board's discretion with regard to arguments advanced by parties through briefs. In *Times-Georgian v. Thompson*, the claimant appealed a decision by the ALJ, which denied his disability benefits. While the claimant did not file a brief within twenty days of the date of her appeal, as required by Board Rule 103(b)(1), she did file a brief at the Board on the date oral argument was held before the members of the full Board. Although the claimant's brief was stamped filed on the date of the oral argument, the employer objected to the untimely filing, and the Board ruled at the oral argument that it would not consider the claimant's brief. At the Board's direction, the words "filed late, not considered" were handwritten on the face of the brief. Nevertheless, in its reversal of the ALJ's decision the full Board specifically referred to the claimant's brief.

The court of appeals ruled that although the full Board would have been within its discretion to allow the late filing of an appellate brief, its failure to allow a responsive brief by the employer denied the employer its fundamental due process rights. The court noted that Rule 103 grants an appellee the right to respond to the appellant's brief, and that under the circumstances, it could not be said that the failure to allow the employer to do so was harmless. The court of appeals did not reverse the entire decision of the full Board, but remanded the case and ordered that the employer be allowed to file a responsive brief.

**Trial Procedure.** As the trier of fact, the Board is given broad discretion to determine factual issues, including the credibility of witnesses. However, this discretion is not without limits. In *Sales* the employer defended against the claimant's allegations of disability, contending that the claimant was malingering for workers' compensation benefits and was not actually injured. As a part of the employer's defense, the employer attempted to introduce evidence concerning a sizeable IRS tax lien filed against Sales, arguing that since workers' compensation benefits are not

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318. Id. at 854-55, 412 S.E.2d at 872.
319. Id. at 855, 412 S.E.2d at 873.
320. Id.
321. Id. at 856, 412 S.E.2d at 874.
324. Id. at 411-12, 416 S.E.2d at 805.
subject to such a lien, Sales was motivated to remain on workers' compensation benefits.\textsuperscript{325} The ALJ refused to allow the employer to cross examine the claimant on this issue, and the court of appeals reversed.\textsuperscript{326}

O.C.G.A. section 34-9-102(e)(1) provides that workers' compensation hearings shall be conducted "in an informal manner consistent with the requirements of due process . . . . A party may conduct such cross examination as required for a full and true disclosure of the facts."\textsuperscript{327} Noting that workers' compensation hearings are subject to the same rules of evidence that apply to civil proceedings, the court of appeals held that the "thorough and sifting cross-examination" requirements of O.C.G.A. section 24-9-64 apply.\textsuperscript{328} Finding that evidence concerning the claimant's motivation for malingering was relevant to the claimant's defense, the court held that the ALJ erred in both excluding this evidence and prohibiting the employer from cross-examining the claimant on this subject.\textsuperscript{329}

In \textit{Red Roof Inn v. Lynn},\textsuperscript{330} the court of appeals also reversed a decision in which a post-hearing doctor's deposition was excluded.\textsuperscript{331} The ALJ allowed the record to remain open for thirty days following the hearing based upon the employer's request to depose two physicians, Drs. Lievano and Kahn. After taking Dr. Kahn's deposition, however, the employer's counsel advised claimant's counsel that he did not intend to depose Dr. Lievano. Claimant's counsel responded by moving to exclude the deposition of Dr. Kahn, which the ALJ granted on the grounds that the record had been left open primarily for taking Dr. Lievano's deposition, and not for the employer's counsel subsequently to decide which of the two depositions would be taken.\textsuperscript{332}

The court of appeals reversed.\textsuperscript{333} The court noted that the ALJ did not indicate at the time he allowed the record to remain open that the right to submit either of the doctor's depositions would be contingent on the taking of the other.\textsuperscript{334} The court also noted that there was no authority requiring that a party to an adversarial proceeding be required to introduce evidence against his will.\textsuperscript{335} Finding that Kahn's testimony may have caused a different result, the court of appeals vacated the Board's award.

\begin{thebibliography}{9}
\bibitem{325} Id. at 411, 416 S.E.2d at 804.
\bibitem{326} Id. at 412, 416 S.E.2d at 805.
\bibitem{328} 203 Ga. App. at 411, 416 S.E.2d at 805.
\bibitem{329} Id. at 412, 416 S.E.2d at 805.
\bibitem{331} Id. at 39, 416 S.E.2d at 309.
\bibitem{332} Id. at 38-39, 416 S.E.2d at 308.
\bibitem{333} Id. at 39, 416 S.E.2d at 309.
\bibitem{334} Id., 416 S.E.2d at 308.
\bibitem{335} Id., 416 S.E.2d at 308-09.
\end{thebibliography}
and ordered the case remanded for consideration of Dr. Kahn's deposition.\textsuperscript{336}

**Proper Forum for Vacating Award on Basis of Fraud.** Two cases during the survey period dealt with the difficult procedural question of how to vacate a final award of the Board when the Board later discovers that the awards were procured on the basis of fraud.

In *Griggs v. All-Steel Buildings, Inc.*,\textsuperscript{337} a steel beam struck the claimant in the face during the course of his employment with All-Steel Buildings, Inc., causing a major head injury. As a result, the claimant suffered severe cognitive and behavioral disorders, and his physician strongly recommended that he be placed in a structured rehabilitative program.\textsuperscript{338} Although these and other reports were available to the employer and its workers' compensation carrier, "the insurer began settlement negotiations with the claimant, who was not represented by counsel."\textsuperscript{339} An agreement was reached in which, in exchange for a release from liability, the claimant agreed to accept the lump sum of $30,000 and $750 per month for twenty-four months. The insurer also agreed to pay past medical expenses, but limited payment for future medical expenses and the costs associated with vocational rehabilitation to those expenses incurred within the next twelve months after approval of the settlement. The parties submitted the settlement agreement to the Board, who subsequently approved it pursuant to O.C.G.A. section 34-9-15.\textsuperscript{340}

Nearly a year later, the claimant, through his mother acting as next friend, filed a request for hearing with the Board, alleging that the employer/insurer failed to provide vocational rehabilitation as required by the settlement agreement. "Subsequently, the claimant filed a motion to set aside the settlement agreement . . . on the grounds that he was incompetent to have entered into it."\textsuperscript{341} Before the Board heard the case, however, the employer/insurer petitioned the superior court, and obtained a judgment on the prior settlement award pursuant to O.C.G.A. section 34-9-106. The ALJ concluded that the Board no longer had jurisdiction of the case, "by virtue of the superior court's judgment and ordered the proceedings before the [B]oard stayed until the superior court could determine if it had jurisdiction in the matter."\textsuperscript{342} The claimant filed a separate motion to set aside in the superior court, which was denied on

\begin{footnotes}
\begin{enumerate}
\item Id., 416 S.E.2d at 309.
\item Id. at 111-12, 410 S.E.2d at 310.
\item Id. at 112, 410 S.E.2d at 310.
\item Id.
\item Id.
\item Id.
\end{enumerate}
\end{footnotes}
the ground that the record before the court was insufficient to justify the claimant's motion.\textsuperscript{343}

After an initial decision and a subsequent motion for reconsideration, the court of appeals framed the issue before it as determining which forum a claimant in a workers' compensation action must use to bring a motion to set aside a prior, final award of compensation.\textsuperscript{344} The court then held that the superior court erred "in denying claimant's motion to set aside the award without first permitting the parties to submit evidence relating to the motion and conducting a hearing on the merits."\textsuperscript{345} The court considered the claimant's motion to set aside on the ground of incompetency tantamount to a motion to set aside on the ground of fraud in the procurement of the settlement, since the allegation was that the employer was aware of his incompetency at the time the settlement agreement was executed.\textsuperscript{346} Although the Board is without statutory authority to review a final award or settlement on the grounds of fraud,\textsuperscript{347} it has long been the law that even a binding award based on an agreement between the parties may be set aside on the grounds of fraud, accident, or mistake.\textsuperscript{348}

The court then took up the difficult task of tracing a long-standing right in equity to challenge the judgment of a court based upon fraud through a series of repealed statutes. Former Georgia Code Annotated section 37-219 was the original statute providing for setting aside awards through an action in equity.\textsuperscript{349} The court noted that when the legislature repealed the statute, the action transferred to O.C.G.A. section 9-11-60(e) as the statute for challenging judgments on the ground of fraud, accident, or mistake.\textsuperscript{350} However, the legislature amended O.C.G.A. section 9-11-60 to extinguish the complaint in equity, and instead provided that a party may bring a motion to set aside on the ground of fraud, accident, or mistake only pursuant to O.C.G.A. section 9-11-60(d). The employer/insurer argued that since the code section refers only to setting aside a "judgment," and not an award of the Board, the claimant was without remedy.\textsuperscript{351} The court rejected this argument, noting that awards of the Board may be reduced to judgments pursuant to O.C.G.A. section 34-9-106, and

\textsuperscript{343} Id.
\textsuperscript{344} Id. at 111, 410 S.E.2d at 310.
\textsuperscript{345} Id. at 112-13, 410 S.E.2d at 311.
\textsuperscript{346} Id. at 113, 410 S.E.2d at 311.
\textsuperscript{347} Id. (citing Simpson v. Liberty Mut. Ins. Co., 99 Ga. App. 629, 109 S.E.2d 876 (1959)).
\textsuperscript{348} Id. (citing Cardin v. Riegel Textile Corp., 217 Ga. 797, 125 S.E.2d 62 (1962)).
\textsuperscript{351} Id.
that since this analysis had allowed complaints in equity under the original statute, the same analysis still applies. In fact, as the court pointed out, the employer/self-insurer had already obtained a judgment based on the Board's decision from a superior court, and therefore an action already existed in the superior court.

The effect of the decision in *Griggs* is to simply reestablish, following the various amendments to O.C.G.A. section 9-11-60, that the proper procedure for setting aside a judgment of the Board based on allegations of fraud is a motion to set aside in the superior court. The court reaffirmed this holding in *Hall & Sosebee Trucking Co. v. Smith*. The facts of *Hall* were similar to *Griggs* in that the moving party was seeking to set aside a final consent agreement filed with the Board. In *Hall*, however, the employer was the one trying to undo a consent agreement in which it agreed to pay workers' compensation benefits based upon allegations that the claimant had obtained this agreement by making fraudulent representations regarding injury and disability. The employer filed a motion with the superior court, denominated as a "complaint in equity," requesting the court to set aside the Board's award on the basis of fraud and misrepresentation. The superior court dismissed the complaint as a claim upon which relief could not be granted, and the court of appeals reversed based upon its earlier decision in *Griggs*. The court further considered, however, the claimant's argument that the employer knew or should have known of the alleged fraud in time to have raised it by direct appeal of the Board's decision under O.C.G.A. section 34-9-105. The court of appeals noted that if, in fact, the employer knew or should have known of the alleged fraud in time to file a direct appeal, then the motion in equity should be dismissed; however, the record was insufficient to make this determination. The case was therefore reversed, and remanded to the superior court for further consideration.

353. *Id.* at 114, 410 S.E.2d at 311.
354. *Id.*
356. *Id.* at 283, 410 S.E.2d at 785.
357. *Id.*
358. *Id.*
359. *Id.*, 410 S.E.2d at 785-86.
360. *Id.*, 410 S.E.2d at 786.
N. Statutory Employer

The decision in *Franks v. Avila* discusses the extent to which a statutory employer is responsible for the direct payment of benefits and penalties to an injured worker of a subcontractor. In *Franks* the claimant fell and injured his neck while working for a subcontractor at a construction project for which Franks was the general contractor. The claimant’s immediate employer had no workers’ compensation coverage, and therefore, the Board found Franks liable for the payment of workers’ compensation benefits as a statutory employer pursuant to O.C.G.A. section 34-9-8(a). In addition, however, the Board also assessed Franks a ten percent penalty for willfully neglecting to provide workers’ compensation coverage. Franks appealed, contending first that no workers’ compensation benefits could be collected from him until the claimant had first established his immediate employer’s insolvency through a judgment against him for benefits and for obtaining a fi. fa. on which a nulla bona had been entered. Second, Franks contended that the Board could not assess a penalty for failure to provide insurance.

The court of appeals rejected Franks’ first argument, noting that nothing within O.C.G.A. section 34-9-8(a) requires the claimant to obtain a judgment in superior court against his or her immediate employer.”

"The purpose of [O.C.G.A. § 34-9-8] is to ensure that employees in construction and other industries are covered by workers’ compensation. In order to do so, it places an increased burden, in the form of potential liability for workers’ compensation benefits, on the statutory employer. This encourages the statutory employer to require subcontractors to carry workers’ compensation insurance.”

Although the claimant must establish that his immediate employer does not have workers’ compensation coverage, the court found that the claimant satisfied this requirement because of the immediate employer’s admission that it had not secured workers’ compensation insurance. The court held that requiring the claimant to go further, and actually obtain a judgment against his immediate employer, was beyond both the requirements of the statute and the remedial purposes of the Act.

362. Id. at 733-34, 409 S.E.2d at 565-66.
363. Id. at 734, 409 S.E.2d at 566.
364. Id. at 733, 409 S.E.2d at 566 (quoting Wright Assocs. v. Rieder, 247 Ga. 496, 499-500, 277 S.E.2d 41, 44 (1981)) (brackets in original).
365. Id. at 734, 409 S.E.2d at 566.
366. Id.
The court reversed, however, with regard to the ten percent penalty. Acknowledging the humane and beneficent purposes of the Act, the court found that there was no suggestion in the record that Franks had either "refused or willfully neglected to maintain insurance." The court, therefore, held that without such a finding, the statutory employer could not be rendered vicariously liable for the acts of the immediate employer.

O. Statute of Limitations

Two cases during the survey period concerned the all-issues statute of limitations in O.C.G.A. section 34-9-82. Both cases help to clarify when the statute bars a claim only for medical benefits. In Wier v. Skyline Messenger Service, the claimant, a courier for Skyline, injured her right knee on June 30, 1988, when she jumped from a loading dock. She lost no time from work as a result of the injury, and she made no claim for income benefits, but she did receive medical treatment from an orthopedic specialist who diagnosed a possible torn cartilage and prescribed exercise at home to strengthen the leg. The claimant aggressively pursued her exercise program, but in November 1989, her knee gave way at home, causing her to return to the authorized treating physician. Since more than one year had passed since the last date of treatment, the employer denied further liability based upon the one year statute of limitations in O.C.G.A. section 34-9-82. O.C.G.A. section 34-9-82(a) provides that:

The right to compensation shall be barred unless a claim therefor is filed within one year after injury, except that if payment of weekly benefits has been made or remedial treatment has been furnished by the employer on account of the injury the claim may be filed within one year after the date of the last remedial treatment furnished by the employer or within two years after the date of the last payment of weekly benefits.

The evidence established that the claimant did not visit the doctor from July 26, 1988, until December 1, 1989. The claimant attempted to avoid the statute of limitations on two grounds. First, she contended that the one year statute of limitations does not apply to "medical-only" claims, based upon the court's previous decision in General Insurance Co. v.

367. Id.
368. Id.
369. Id.
371. Id. at 674, 417 S.E.2d at 694-95.
373. 203 Ga. App. at 675, 417 S.E.2d at 695.
Bradley.\textsuperscript{374} As the court properly noted, however, the decision in Bradley concerned an entirely different statute of limitations, namely the “change in condition” statute of limitations in O.C.G.A. section 34-9-104.\textsuperscript{375} The change in condition statute applies only to cases in which income benefits have been paid.\textsuperscript{376} Whether the statute of limitations applies to medical benefits, therefore, depends upon whether any income benefits have been paid. If so, then the “change in condition” statute applies, and no statute of limitations as to medical benefits exists. If, however, the employer has not paid income benefits, and the case is only a “medical-only” claim, then the one year statute of limitations found in O.C.G.A. section 34-9-82 is still applicable.\textsuperscript{377}

Wier’s second argument was that her physical therapy at home constituted ongoing remedial treatment furnished by the employer, such that the statute did not begin to run until one year after her physical therapy, which went on long after the last date the employer actually paid for her medical treatment. The court also rejected this argument, finding that at home physical therapy did not constitute “remedial treatment” as defined by O.C.G.A. section 34-9-200(a), and therefore, the statute began to run on the last date the claimant saw her authorized treating physician.\textsuperscript{378} Therefore, the statute of limitations barred Wier’s claim for additional medical and indemnity benefits.\textsuperscript{379}

The court of appeals also discussed the all-issues statute of limitations in American International Adjusting Co. v. Davis.\textsuperscript{380} The court determined that the occupational disease statute of limitations, found in O.C.G.A. section 34-9-281(b)(2), controlled the decision.\textsuperscript{381} A physician diagnosed Davis on September 9, 1988, as having work-related pneumoconiosis as a result of his exposure to kaolin dust at work. Other physicians subsequently confirmed this diagnosis in separate examinations on October 17, 1988, and November 3, 1988. The claimant applied for, and received, full group disability and medical benefits through the employer. He also retained an attorney on October 27, 1988, for assistance in making a workers’ compensation claim. Claimant’s counsel requested medical records from the employer on December 3, 1988, a day after the employer filed a first report of injury and notice to controvert payment of compensation with the Board. The claimant retained new counsel in October,
1989, and claimant's second attorney filed a claim for benefits on October 4, 1989.82

The Board concluded that the occupational disease statute of limitations barred the claim, but on appeal the superior court reversed, finding that the all-issues statute of limitations in O.C.G.A. section 34-9-82(a) was applicable, and that the medical treatment paid for by the group insurance carrier constituted medical treatment furnished by the employer so as to toll the statute of limitations.83 The court of appeals reversed the superior court, and reinstated the Board's denial of the claim.84

The court of appeals first noted that the Board properly applied the occupational disease statute of limitations, since the claimant's condition was clearly an occupational disease as defined by O.C.G.A. section 34-9-280(2).85 The statute of limitations for an occupational disease provides that a claim in such a case must be filed within one year after the date "the employee knew or, in the exercise of reasonable diligence, should have known of the disablement and its relationship to the employment."86 The record established, through the claimant's own testimony, that he knew of his condition and its work-related cause on September 9, 1988, but did not file a claim until over a year later. These facts barred the claim under the occupational disease statute of limitations.87

The court went to great lengths, however, to show that even if the all-issues statute applied, it also would bar the claim.88 The court took the opportunity to point out that an employer's processing of a claim for group disability and medical benefits does not necessarily make such treatment remedial treatment under the Act that would toll the statute of limitations.89 The court specifically found that the group disability benefits paid to the claimant were not "weekly benefits . . . on account of injury,"90 another means of tolling the statute of limitations.91 The court thereby distinguished the case from another recent and controversial decision in which the court of appeals found that the salary paid by an employer had operated to toll the statute of limitations.92

The court noted that even if the court held that the employer should have provided the medical treatment, the treatment claimant received in

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382. Id. at 276-77, 414 S.E.2d at 293.
383. Id. at 277, 414 S.E.2d at 291.
384. Id. at 280, 414 S.E.2d at 295.
385. Id. at 277, 414 S.E.2d at 293.
388. Id. at 278-79, 414 S.E.2d at 294-95.
389. Id., 414 S.E.2d at 294.
1988 was diagnostic rather than remedial. In other words, the medical treatment received by the claimant was merely to identify his condition, not to effect a cure or give relief. Since the treatment was not remedial, it could not operate to toll the statute of limitations. This ruling is significant because it will allow employers to provide initial diagnostic treatment without fear of tolling the statute of limitations.

The court also stated that the employer's actions in processing the claimant's group disability claim did not induce the claimant to avoid filing a workers' compensation claim. The court noted that the claimant retained counsel early on in the case for the express purpose of pursuing the workers' compensation claim, and also noted the lack of any evidence in the case demonstrating that the actions of the employer could reasonably be interpreted as misleading the claimant into not filing a claim for compensation benefits. Although the court's discussion of the all-issues statute in *Davis* is dicta, since the court applied the occupational disease statute of limitations, the court's review of the various loopholes argued by the claimant is instructive for use in future cases.

P. Subsequent Injury Trust Fund

Although the court of appeals historically has decided very few Subsequent Injury Trust Fund ("SITF") cases, it has issued three such decisions within the last year. The first, *Brockway Standard v. Harper*, clarified a fundamental concept in the definition of "merger." The employer attempted to establish merger under O.C.G.A. section 34-9-351(1)(B), which states that merger exists when "the disability resulting from the subsequent injury in conjunction with the pre-existing permanent impairment is materially, substantially, and cumulatively greater than that which would have resulted had the pre-existing permanent impairment not been present." The ALJ denied reimbursement, however, on the grounds that the employer failed to establish merger under O.C.G.A. section 34-9-351(1)(A), which requires a finding that the subsequent injury would not have occurred if the pre-existing injury had not been present. On appeal, the full Board affirmed the ALJ decision, and further held that, in order to prove merger, the employer must meet the requirements of both subsections (A) and (B).
The court of appeals reversed.\textsuperscript{399} The court noted that the phrasing of the statute clearly demonstrates that the two definitions of merger are separate, distinct, and do not "require the satisfaction of any combination of the provisions."\textsuperscript{400} An employer may, therefore, establish merger solely by demonstrating that the cumulative effect of the pre-existing impairment and the subsequent injury was materially and substantially greater, and need not demonstrate the causal relationship required by subsection (A).\textsuperscript{401}

\textit{Georgia Subsequent Injury Trust Fund v. Lumley Drywall}\textsuperscript{402} presented the interesting question of whether a sole proprietor who elects coverage for workers' compensation qualifies as an employer entitled to reimbursement from SITF. Lumley, sole proprietor of Lumley Drywall, elected to be included as an employee for workers' compensation purposes pursuant to O.C.G.A. section 34-9-2.2. When he subsequently injured himself on the job, Lumley filed a claim against SITF based upon his own personal knowledge of his pre-existing back injury.\textsuperscript{403} Lumley was, therefore, both employee and employer in the claim against SITF and the sole basis of employer knowledge of the pre-existing impairment.

The SITF rejected the claim for reimbursement, arguing that employer knowledge cannot be satisfied by a sole proprietor who has hired himself as an employee. The Board disagreed, however, and the court of appeals affirmed.\textsuperscript{404} The court of appeals held that:

to argue that it is illogical for persons to conclude that they are disabled and to then go into business for themselves begs the question and ignores the problems that disabled persons have in finding suitable employment . . . . We should not discourage self-employment and employment of the handicapped by barring reimbursement from the Fund on the basis of technical distinctions not found in the Act. Instead of encouraging employment, the Fund would seek to create a class of employers who must bear the increased cost of pre-existing conditions even though they are required by law to contribute to the Fund.\textsuperscript{405}

The court, therefore, held that sole proprietors, who have hired themselves with knowledge of a pre-existing impairment, can satisfy the employer knowledge requirement for reimbursement from SITF.\textsuperscript{406}

\begin{footnotes}
\item[399] Id. at 251, 407 S.E.2d at 477.
\item[400] Id.
\item[401] Id.
\item[403] Id. at 704, 409 S.E.2d at 255.
\item[404] Id. at 704-06, 409 S.E.2d at 255-56.
\item[405] Id. at 705, 409 S.E.2d at 256.
\item[406] Id., 409 S.E.2d at 255.
\end{footnotes}
JPS Carpets v. Troupe provides an example of insufficient evidence of merger. Troupe injured her right knee at work in 1981, and received workers' compensation benefits for a brief time, and ultimately received a fifteen percent permanent partial disability to her right lower extremity. She returned to her regular job, but occasionally experienced pain and swelling in her knee. Troupe injured herself again in 1987 when she tripped and fell, injuring her right side, right arm, and shoulder. She did not regain the use of her right arm, and was unable to resume her employment. She received a five percent permanent partial disability rating to her upper extremity for the subsequent injury in 1987. The employer requested reimbursement from SITF, but the Board rejected the claim on the basis that the employer had not established merger between the 1981 pre-existing impairment and the 1987 subsequent injury.

At the ALJ hearing, Troupe testified that the 1987 accident happened when she caught her left knee in a hole in the pavement, causing all of her weight to shift to her injured right leg, which buckled at the knee because it could not support the weight. An accident report completed by the employer within twenty-four hours of the injury, however, contained no mention of Troupe's knee buckling, nor did any of the medical records of the claimant's treatment for this injury. Notwithstanding Troupe's testimony regarding her injury, the ALJ found that the pre-existing permanent impairment did not cause the 1987 accident, and further concluded that the claimant's degree of disability was not materially, cumulatively, or substantially greater because of the pre-existing knee impairment. The ALJ and the full Board concluded that the claimant's disability was the result of her 1987 right arm problems, and was no greater because of the pre-existing knee injury.

The court of appeals treated this as an "any evidence" case, finding the lack of information in the accident report and medical records sufficient evidence for the Board to conclude that no causal connection existed between the pre-existing impairment and the subsequent injury. The court also found the evidence sufficient to substantiate the Board's conclusion that the claimant's disability was not substantially greater because of her pre-existing impairment.

408. Id. at 602-03, 417 S.E.2d at 333-34.
409. Id.
410. On appeal, findings by the Board are conclusive if supported by "any evidence." Howard Sheppard, Inc. v. McGowan, 137 Ga. App. 408, 224 S.E.2d 65 (1976).
412. Id., 417 S.E.2d at 335.
IV. Conclusion

Over past years, much discussion has ensued concerning ways to streamline litigation. In the area of workers' compensation, the discussion concerns how to save costs for employers/insurers and at the same time provide sufficient benefits to the employees. This was certainly one of the many goals of the 1992 legislative changes. Taking into consideration the breadth of those changes, and the Americans with Disabilities Act, the upcoming survey period should produce some interesting decisions. Whether we will actually see less litigation, more savings to the employers/insurers, and more benefits to the employees, however, remains to be seen.