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Workers' Compensation

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Workers' Compensation

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The Georgia General Assembly made no substantive changes to the Workers' Compensation Act[1] in 2008. Additionally, the Georgia appellate courts took relatively few cases on appeal, and most of these addressed areas of law that are already well-established. Because many workers' compensation cases now require practitioners to address the Medicare Secondary Payer Act,[2] the history, impact, and involvement of that legislation on Georgia claims is also addressed in this Article.

I. EXCLUSIVE REMEDY

There were two cases decided by the Georgia Court of Appeals during the survey period addressing the exclusive remedy provision of the Workers' Compensation Act,[3] and in both, the exclusive remedy was upheld.

McLeod v. Blase[4] involved the application of the exclusive remedy to co-employees who render medical care. A professional basketball player for the Atlanta Hawks, Roshown McLeod, filed a professional malprac-

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1. O.C.G.A. §§ 34-9-1 to -421 (2008).
2. 42 U.S.C. § 1395y(b) (2000 & Supp. V 2005).
3. O.C.G.A. § 34-9-11(a) (2008).
4. 290 Ga. App. 337, 659 S.E.2d 727 (2008).

tice action against Walter Blase, a certified athletic trainer, employed by the Atlanta Hawks in the sports medicine department. It is important to note that the trial court found that Blase was McLeod's co-employee. McLeod alleged that he was injured while playing for the Hawks in July of 2000, Blase negligently treated his injury, and as a result, McLeod's otherwise-treatable injury became permanent and rendered him disabled from playing professional basketball.[5]

McLeod attempted to avoid the exclusive remedy doctrine by arguing that actions for professional malpractice are generally excepted from the exclusive remedy provision of the Act. Rejecting McLeod's contention, the trial court held that the exception for professional malpractice was applicable only to physician co-employees sued for medical malpractice. Consequently, the court ruled that Blase was entitled to immunity from McLeod's tort claim under the exclusive remedy provision of the Workers' Compensation Act and granted Blase summary judgment. McLeod appealed.[6]

The exclusive remedy provision of the Act precludes an injured employee from bringing a tort action against the employer as well as any co-employees of the same employer.[7] However, it does not prevent the employee from bringing a tort action against any third party tortfeasor.[8] The Georgia Supreme Court recognized an exception to the immunity of co-employees in *Downey v. Bexley*.[9] There, the court held that a professional co-employee may be held liable in tort for his wrongdoing to an injured employee when the co-employee is charged with fraud, deceit, and violation of professional trust.[10] The court reasoned that professional persons owe a unique duty to others, as opposed to an individual who works in a purely commercial enterprise.[11] The supreme court recognized another exception to the immunity of co-employees in *Davis v. Stover*.[12] There, the court held that because of the relationship of trust between physicians and patients, company physicians cannot use the Act to insulate themselves from individual liability for medical malpractice claims.[13]

The court of appeals in *McLeod* held that the trial court correctly granted the defendant's motion for summary judgment because the

5. *Id.* at 337-38, 659 S.E.2d at 728-29.
6. *Id.* at 337, 659 S.E.2d at 728.
7. O.C.G.A. § 34-9-11(a).
8. *Id.*
9. 253 Ga. 125, 317 S.E.2d 523 (1984).
10. *Id.* at 125-26, 317 S.E.2d at 524.
11. *Id.* at 126, 317 S.E.2d at 524.
12. 258 Ga. 156, 366 S.E.2d 670 (1988).
13. *Id.* at 157, 366 S.E.2d at 671-72.

Downey and *Davis* exceptions to co-employee tort immunity under the Act did not apply to actions against certified athletic trainers.[14] The court noted that although language in those two cases suggested that the exception to the co-employee immunity could apply to other professionals besides physicians, the exception had thus far only been applied when a medical malpractice action was brought against a company physician.[15] The court determined that there was no controlling authority for the premise that an employee could bring a medical malpractice action against a certified trainer, or any other professional, simply because that person was subject to the authority of a professional licensing board.[16] Additionally, the court distinguished between physicians and certified trainers because certified trainers are not held to the same obligations of public interest and trust that override the duties of co-employees, as are physicians.[17]

In *Coker v. Great American Insurance Co.*,[18] summary judgment was granted to an insurer on the grounds that it was immune from suit under the exclusive remedy provision because the insurer provided workers' compensation benefits to the employee through one of its wholly owned subsidiaries. While working for Mayo Company, Inc. (Mayo), Coker severed multiple fingers while using a shearing machine. Coker brought a tort action against Deep South Surplus of Georgia (Deep South) and Great American Insurance Company (Great American).[19] Coker relied on the court of appeals' prior decision in his 2002 action against Deep South,[20] the company hired by American National to perform a safety inspection of Mayo's premises.[21] In the 2002 case, Coker successfully appealed the trial court's grant of summary judgment to the defendant because Deep South was not Mayo's employer or the workers' compensation carrier of his employer.[22]

In this case, however, Great American filed a motion for summary judgment claiming that it had tort immunity under the exclusive remedy provision of the Workers' Compensation Act. Great American contended that it provided workers' compensation benefits to Mayo through one of its wholly owned subsidiaries, American National Fire Insurance Company (American National). American National received premiums

14. *McLeod*, 290 Ga. App. at 340-41, 659 S.E.2d at 730-31.
15. *Id.* at 340, 659 S.E.2d at 730.
16. *Id.*; *See* O.C.G.A. §§ 43-5-1 to -15 (2008).
17. *McLeod*, 290 Ga. App. at 340-41, 659 S.E.2d at 730-31.
18. 290 Ga. App. 342, 659 S.E.2d 625 (2008).
19. *Id.* at 342, 659 S.E.2d at 626.
20. Coker v. Deep S. Surplus of Ga., 258 Ga. App. 755, 574 S.E.2d 815 (2002).
21. *Great American*, 290 Ga. App. at 342, 659 S.E.2d at 626.
22. *Deep South*, 258 Ga. App. at 757, 574 S.E.2d at 817.

directly from Mayo and was directly liable for paying workers' compensation claims on their behalf. Summary judgment was granted to Great American, and Coker appealed.[23]

Under Official Code of Georgia Annotated (O.C.G.A.) § 34-9-1(3),[24] the term "insurer" is equated with the term "employer" to the extent that an insurer is considered the alter ego of the employer for purposes of immunity.[25] Accordingly, the court determined that while Deep South was not immune from tort liability, because it was merely a third-party capable of being sued, Great American was immune.[26] The basis for the differentiation was that National American was a wholly owned subsidiary of Great American, and Great American provided workers' compensation benefits to the plaintiff on behalf of his employer.[27] Under Georgia law, a parent corporation of a wholly owned subsidiary that is entitled to immunity under the Act is considered the subsidiary's alter ego and, therefore, shares in the immunity.[28] Accordingly, the court of appeals affirmed the trial court's grant of summary judgment.[29]

II. INGRESS AND EGRESS

Champion v. Pilgrim's Pride Corp. of Delaware[30] also involved the exclusive remedy provision, but the primary concept that the Georgia Court of Appeals addressed was the doctrine of reasonable ingress and egress.[31] The decedent was struck and killed by a tractor trailer operated by a co-employee of the defendant, Pilgrim's Pride, as he backed the vehicle into the receiving area. Whether the accident arose out of and in the course of the decedent's employment became a pivotal issue in determining the viability of the tort action.[32]

The decedent was struck approximately seventy-eight minutes prior to her shift, and it was company policy that employees could not clock in more than thirty minutes before their shifts started. It was undisput-

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23. *Great American*, 290 Ga. App. at 342, 659 S.E.2d at 626.
24. O.C.G.A. § 34-9-1(3) (2008).
25. *Great American*, 290 Ga. App. at 343, 659 S.E.2d at 626.
26. *Id.*, 659 S.E.2d at 626-27.
27. *Id.* at 345, 659 S.E.2d at 628.
28. *Id.; see* Collins v. Sheller-Globe Corp., 194 Ga. App. 263, 390 S.E.2d 294 (1990); *see also* Crisp Reg'l Hosp. v. Oliver, 275 Ga. App. 578, 621 S.E.2d 554 (2005); *see generally* Beck v. Flint Constr. Co., 154 Ga. App. 490, 268 S.E.2d 739 (1980).
29. *Great American*, 290 Ga. App. at 345, 659 S.E.2d at 628.
30. 286 Ga. App. 334, 649 S.E.2d 329 (2007).
31. *See id.* at 338-39, 649 S.E.2d at 332-33.
32. *Id.* at 334, 649 S.E.2d at 330.

ed that the decedent only required ten minutes to prepare for her shift.[33]

In the wrongful death suit filed by the decedent's daughter, Tlisa Champion (Champion), who was seeking damages upon claims of premises liability, negligence, negligence per se, and respondeat superior, the defendant filed a motion for summary judgment based on its contention that the claims were barred under the exclusive remedy provision of the Act. The motion for summary judgment was granted by the trial court.[34]

On appeal, the defendant contended that the injury occurred within a reasonable time for ingress to the work station, because it would have taken the decedent at least five minutes to walk to her work station, and she was injured within three minutes of starting her walk.[35] The court of appeals held that when determining whether an employee is within the scope of employment in traveling to and from work, the period of employment includes a reasonable time for ingress and egress from the place of work, which is not defined as the amount of time necessary to reach the employee's work station but rather the length of time between the accident and the time the shift was scheduled to start.[36] Here, the injury occurred seventy-eight minutes prior to the start of the decedent's shift, which meant that the accident occurred forty-eight minutes before the decedent was allowed to clock in, per the defendant's policy.[37] The court of appeals reversed the grant of summary judgment and remanded based upon the conclusion that a jury question existed regarding whether the decedent was within the scope of employment at the time that she was on the employer's premises.[38]

III. TEMPORARY AGGRAVATION OF PRE-EXISTING CONDITION

In *Bibb County Board of Education v. Bembry*,[39] Sandra Bembry, a sixth-grade teacher for the Bibb County Board of Education, was injured when she fell over some books at a work meeting. Bembry sought treatment with the authorized treating physician, Dr. Godlewski, who diagnosed her with multiple sprains of the lumbar spine and leg. The medical records indicated that Bembry had a pre-existing disc herniation

33. *Id.* at 335, 649 S.E.2d at 330.
34. *Id.* at 334-35, 649 S.E.2d at 330.
35. *Id.* at 338, 649 S.E.2d at 332.
36. *Id.* at 338-39, 649 S.E.2d at 332 (quoting U.S. Cas. Co. v. Russell, 98 Ga. App. 181, 182, 105 S.E.2d 378, 379 (1958)).
37. *Id.* at 339, 649 S.E.2d at 332.
38. *Id.*
39. 286 Ga. App. 878, 650 S.E.2d 427 (2007).

condition for which she had received treatment from Dr. Wilson, her personal physician.[40]

After treating Bembry approximately ten times, Dr. Godlewski opined that the muscular sprains Bembry suffered as a result of the work-related injury had resolved to at least her pre-injury baseline. Specifically, Dr. Godlewski testified that while a precise medical baseline could not be determined, he believed that the sprains caused by her injury were resolved. He explained that Bembry's prior symptoms indicated that she experienced a disc herniation six months to two years prior to the work-related injury. Dr. Godlewski concluded that the work-related injury had affected the musculature only and did not aggravate the degenerative disc disease. Dr. Godlewski requested Dr. Wilson's opinion regarding the resolution of the work-related injury, and Dr. Wilson responded that Bembry's previous condition had definitely been aggravated by her on-the-job fall and that she had not returned to her baseline status.[41]

The Bibb County Board of Education controverted payment of further medical benefits, and Bembry filed a hearing request seeking continuing benefits and attorney fees. The Administrative Law Judge (ALJ) held that Bembry did not meet her burden of proof to show she needed continued benefits, relying primarily upon the opinion of the authorized treating physician, Dr. Godlewski. The Appellate Division of the State Board of Workers' Compensation (State Board) found that the ALJ's findings were supported by a preponderance of competent and credible evidence. On appeal, the superior court reversed the decision of the State Board, awarding benefits to Bembry and remanding the matter for determination of whether attorney fees should be assessed. Arguing that the superior court acted outside the scope of its authority in reversing the State Board's determination because there was evidence supporting its decision,[42] the Bibb County Board of Education appealed to the court of appeals.[43]

Bembry contended throughout the proceedings that Dr. Godlewski's testimony should have been trumped by Dr. Wilson, who expressed a "definitive" opinion regarding aggravation, because Dr. Godlewski could

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40. *Id.* at 878-79, 650 S.E.2d at 428.

41. *Id.*

42. *Id.* at 879, 650 S.E.2d 428-29; *see* Reid v. Ga. Bldg. Auth., 283 Ga. App. 413, 641 S.E.2d 642 (2007) (holding that in reviewing an award of workers' compensation benefits, the superior court and the court of appeals are required to construe the evidence in a light most favorable to the party prevailing before the State Board and that the findings of the Board are conclusive and binding when supported by any evidence).

43. *Bembry*, 286 Ga. App. at 879, 650 S.E.2d at 429.

not say with medical certainty that Bembry had returned to her pre-injury baseline.[44] The court of appeals rejected this contention and held that in the context of workers' compensation claims, expert medical conclusions need only "medical probability" and do not have to be stated in the form of medical certainty.[45] Accordingly, the court concluded that "the [State] Board properly considered Dr. Godlewski's opinion as evidence that [the] work-related injury had resolved."[46]

The court of appeals reversed the superior court, holding that Georgia law is clear that findings of the State Board of Workers' Compensation are conclusive and binding if there is any evidence to support the findings.[47] Additionally, the weight and credit to be given to witness testimony and the conflicts in the evidence are matters for the Board, and this includes the weight and credit to be given to the opinion testimony of a physician witness when there are conflicting physicians' opinions.[48] Accordingly, the court of appeals determined that Dr. Godlewski's testimony was evidence that supported the State Board's findings that any aggravation by the work injury was temporary and was resolved, despite the fact that Bembry presented Dr. Wilson's letter as evidence indicating that she had not returned to her baseline status.[49] Thus, since the State Board did not exceed the scope of its authority in making a credible determination of the conflicting expert opinions, the superior court erred when it disturbed the State Board's determination.[50]

IV. SUBROGATION

In *Paschall Truck Lines, Inc. v. Kirkland,*[51] the "fully and completely compensated" requirement of the subrogation section[52] of the Workers' Compensation Act[53] was challenged. In the underlying action, Kirkland was driving a truck for Paschall when he was hit by a third party.

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44. *Id.* at 880, 650 S.E.2d at 429.

45. *Id.*; *see* Am. Fire & Cas. Co. v. Gay, 104 Ga. App. 840, 123 S.E.2d 287 (1961).

46. *Bembry*, 286 Ga. App. at 881, 650 S.E.2d at 429.

47. *Id.* at 879, 650 S.E.2d at 429; *see* Worthington Indus. v. Sanks, 228 Ga. App. 782, 492 S.E.2d 753 (1997); *see* Wilson v. Aragon Mills, 110 Ga. App. 392, 138 S.E.2d 596 (1964); *see also* Diers v. House of Hines, Inc., 168 Ga. App. 282, 308 S.E.2d 611 (1983).

48. *Bembry*, 286 Ga. App. at 879-80, 650 S.E.2d at 429; *See Worthington Indus.*, 228 Ga. App. at 783, 492 S.E.2d at 754-55; *see* Elbert County Bd. of Comm'rs v. Burnett, 200 Ga. App. 379, 408 S.E.2d 168 (1991).

49. *Bembry*, 286 Ga. App. at 880, 650 S.E.2d at 429.

50. *Id.*

51. 287 Ga. App. 497, 651 S.E.2d 804 (2007).

52. O.C.G.A. § 34-9-11.1(b) (2008).

53. O.C.G.A. §§ 34-9-1 to -421 (2008).

Kirkland filed a workers' compensation claim against Paschall in Georgia, where Kirkland was a resident and where the accident occurred. Additionally, Kirkland filed a workers' compensation claim in Kentucky, where Paschall's main office was located, and he received indemnity and medical benefits pursuant to Kentucky law.[54]

Subsequently, the Georgia State Board of Workers' Compensation approved a stipulation and agreement entered into by the parties to the claim. When Kirkland filed suit in Georgia against the third party driver who hit him and the driver's employer, Paschall moved to intervene, asserting a subrogation lien for the workers' compensation benefits that it had paid to Kirkland. After settling the personal injury claim, Kirkland filed a motion to extinguish Paschall's subrogation lien against the settlement proceeds, claiming that Paschall could not exercise a subrogation lien under Georgia law because Kirkland received his workers' compensation benefits under Kentucky law.[55] The trial court agreed with Kirkland and granted his motion, construing it as a motion for partial summary judgment.[56]

On appeal, Paschall asserted that as the non-movant on the motion for summary judgment, the trial court erred in construing the stipulation and settlement agreement against Paschall. Specifically, Paschall argued that it was error to find that no issue of fact existed on whether the benefits were paid under Georgia or Kentucky law or both because the settlement agreement did not expressly state under which state's laws the indemnity and medical benefits were paid to Kirkland. Additionally, the settlement amount was not paid until after the Georgia State Board had approved the agreement. Furthermore, Paschall argued there was language in the agreement suggesting that the consideration was in exchange for settling both claims and that the employer and insurer still maintained a subrogation interest against a third party tortfeasor.[57]

The Georgia Court of Appeals declined to address whether the trial court correctly determined that Paschall had a subrogation lien because no benefits had been paid under Georgia law.[58] Rather, the court determined that Paschall failed to meet a threshold burden of proof at

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54. *Kirkland*, 287 Ga. App. at 497, 651 S.E.2d at 805.

55. *Kirkland*, 287 Ga. App. at 497, 651 S.E.2d at 805; *see* Johnson v. Comcar Indus., 252 Ga. App. 625, 626, 556 S.E.2d 148, 150 (2001) (holding that O.C.G.A. § 34-9-11.1(b) provides for a right of subrogation that is limited to benefits paid under the Georgia Workers' Compensation Act).

56. *Kirkland*, 287 Ga. App. at 497-98, 651 S.E.2d at 805.

57. *Id.* at 498, 651 S.E.2d at 806.

58. *Id.* at 498-99, 651 S.E.2d at 806.

the trial court level because Paschall offered no evidence supporting that Kirkland had been fully and completely compensated for his injury, which is a required showing for an employer's subrogation lien to be enforceable under O.C.G.A. § 34-9-11.1(b).[59] The court also reinforced the principle that a court reviewing a lump sum settlement cannot determine what portion of a settlement was allocated to economic and noneconomic losses just by looking at the settlement documents.[60] Consequently, a lien cannot be enforced because full and complete compensation cannot be shown.[61]

V. SUPERIOR COURT APPEAL

In *YKK (USA), Inc. v. Patterson*,[62] the ALJ found, and the Appellate Division of the Board affirmed, that Kimberly Patterson was not entitled to benefits because she did not show by a preponderance of the evidence that she sustained an injury arising out of and in the course of her employment.[63] The medical evidence showed that Patterson went to the emergency room after noticing that her right leg was red and swollen. She was diagnosed with cellulitis. She told her coworkers and treating physicians that she was unaware of what caused the swelling and that she had not injured herself. Ultimately, she was diagnosed with complex regional pain syndrome. At the hearing, Patterson alleged that she tore a leg muscle while pushing a cart at work, and she offered the testimony of her family physician in support. The physician testified that an MRI of Patterson's leg showed a contusion or strain of unknown age. Patterson also tendered a report from her orthopedic surgeon, who diagnosed her with the same pain syndrome but was unsure whether the condition was caused or aggravated by work conditions. Further, Patterson relied on a deposition and narrative report from her physical medicine and rehabilitation physician, who opined that the MRI showed an abnormality near the ankle that could have been a muscle strain or tear that was caused by Patterson pushing the tool cart. Additionally, the ALJ considered the deposition of Patterson's occupational medicine physician, who noted no indication of muscular injury and opined that the condition was unrelated to her work.[64]

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59. *Id.* at 499, 651 S.E.2d at 806 (citing City of Warner Robins v. Baker, 255 Ga. App. 601, 604, 565 S.E.2d 919, 922 (2002)).

60. *Id.* (quoting *Baker*, 255 Ga. App. at 604, 565 S.E.2d at 923).

61. *Id.*

62. 287 Ga. App. 537, 652 S.E.2d 187 (2007).

63. *Id.* at 537, 652 S.E.2d at 188.

64. *Id.* at 538, 652 S.E.2d at 189.

In reversing the Board's decision, the superior court found that the ALJ had overlooked certain evidence, including that Patterson complained of pain immediately after the alleged accident, and the court remanded the case back to the ALJ for further consideration.[65] The Georgia Court of Appeals granted the application for discretionary review filed by YKK based upon the argument that the superior court had exceeded its authority in vacating the decision by the Board, which was supported by some evidence.[66] The court of appeals agreed with YKK.[67]

Under O.C.G.A. § 34-9-105,[68] a superior court is statutorily authorized to set aside an award of the Board based on certain specific grounds and may recommit the controversy back to the Board for further proceedings.[69] However, the superior court is not entitled to remand the case directly to the ALJ and may only remand to the Appellate Division.[70] Accordingly, the court of appeals held that the superior court erred when it remanded the case to the ALJ.[71]

Furthermore, YKK argued that the superior court erred when it vacated the Board's award because there was evidence to support the award.[72] The court of appeals agreed, reasoning that the Appellate Division of the Board generally adopted the ALJ's findings, and the Board's award was clear that it did not base its decision on Patterson's failure to report pain immediately after the alleged injury.[73] Instead, the Board found that Patterson had failed to prove a compensable claim by a preponderance of the evidence because none of the physicians who treated Patterson on the day of her alleged injury had diagnosed her with a work-related injury, nor did any of them determine the cause of her leg condition.[74] Furthermore, only one doctor concluded that there

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65. *Id.* at 538-39, 652 S.E.2d at 189.

66. *Id.* at 537, 652 S.E.2d at 188 (quoting Bibb County Bd. of Educ. v. Bembry, 286 Ga. App. 878, 650 S.E.2d 427 (2007)); *see* Reid v. Ga. Bldg. Auth., 283 Ga. App. 413, 641 S.E.2d 642 (2007) (holding that in reviewing an award of workers' compensation benefits, the superior court and the court of appeals are required to construe the evidence in a light most favorable to the party prevailing before the State Board and that the findings of the Board are conclusive and binding when supported by any evidence).

67. *Patterson*, 287 Ga. App. at 539, 652 S.E.2d at 189.

68. O.C.G.A. § 34-9-105 (2008).

69. *Patterson*, 287 Ga. App. at 539, 652 S.E.2d at 189; *see* O.C.G.A. § 34-9-105(c), (d).

70. *Patterson*, 287 Ga. App. at 539, 652 S.E.2d at 189-90; Satilla Reg. Med. Ctr. v. Corbett, 254 Ga. App. 576, 578, 562 S.E.2d 751, 753 (2002).

71. *Patterson*, 287 Ga. App. at 539, 652 S.E.2d at 189-90.

72. *Id.*, 652 S.E.2d at 190; *see Bembry*, 286 Ga. App. at 879, 650 S.E.2d at 429; *Reid*, 283 Ga. App. at 416, 641 S.E.2d at 646.

73. *Patterson*, 287 Ga. App. at 539, 652 S.E.2d at 190.

74. *Id.* at 539-40, 652 S.E.2d at 190.

was a work injury and that doctor did not start treating Patterson until one year after the alleged date of injury.[75] The court of appeals held that the Board was authorized to weigh the evidence, including the physicians' opinions, and to conclude that Patterson had not suffered a compensable injury.[76] Accordingly, the superior court was constricted to affirm the award of the Board.[77] The court of appeals reversed the superior court's ruling and reinstated the award of the Board.[78]

VI. STATUTORY EMPLOYMENT

In a case concerning several employers involved in cutting and transporting timber, a little-used provision of O.C.G.A. § 34-9-8[79] was found to protect an alleged statutory employer.[80] In *Axson Timber Co. v. Wilson*,[81] the various relationships of the entities were important. Axson Timber Company (Axson) contracted to buy timber and then hired Rice Timber Company (Rice) to actually cut the timber. In turn, Rice then hired White Trucking Company to haul the cut timber to a customer's mill. Kenneth Wilson was a truck driver for White Trucking, and he was injured at a mill in Florida when he stepped out of his truck, fell, and hurt his back.[82]

Wilson filed a claim and was found to be an employee of White Trucking, which did not have workers' compensation insurance. Because White Trucking did not have insurance, Wilson sought to hold either Rice or Axson liable as statutory employers.[83]

Under O.C.G.A. § 34-9-8(a), a principal, intermediate, or subcontractor is equally liable for compensation as the uninsured employer, if the employee is injured while in the employ of any of the subcontractors engaged upon the subject matter of the contract, to the same extent as the immediate employer.[84] However, under O.C.G.A. § 34-9-8(d), the injury must have "occurred on, in, or about the premises on which the principal contractor has undertaken to execute work or which are otherwise under his control or management."[85]

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75. *Id.* at 540, 652 S.E.2d at 190.
76. *Id.*
77. *Id.*
78. *Id.*
79. O.C.G.A. § 34-9-8 (2008).
80. *See* Axson Timber Co. v. Wilson, 286 Ga. App. 482, 649 S.E.2d 609 (2007).
81. 286 Ga. App. 482, 649 S.E.2d 609 (2007).
82. *Id.* at 482, 649 S.E.2d at 610.
83. *Id.*
84. O.C.G.A. § 34-9-8(a).
85. *Id.* § 34-9-8(d).

The ALJ, the Appellate Division, and the superior court found that Rice was liable as the statutory employer under O.C.G.A. § 34-9-8(d) because Rice controlled or managed the premises where the accident occurred. The ALJ found that the shipping destination (in this case, a mill in Florida) was no different than the highway along which the goods were shipped.[86] The ALJ relied on a 1971 case which determined that a trucking employee, who stopped on a South Carolina highway to shift his load and was injured when he fell from the truck, was injured on the "premises" of the trucking company, basically making a finding that a trucker's work premises would essentially be the highway upon which he drove.[87]

However, the Georgia Court of Appeals disagreed with this finding, stating that a later case, decided in 1982, determined that a shipper does not have control or management of the destination,[88] and the court thus reversed the ALJ in Wilson's case.[89] The 1982 case was *Gramling v. Sunshine Biscuits, Inc.*,[90] and that case was similar to the Wilson case in that the truck driver was injured at the destination when he fell while unloading his trailer.[91] While *Gramling* was a tort case, the holding was found applicable in *Axson Timber*, and the court reiterated that the intent of the Workers' Compensation Act[92] was not to impose workers' compensation liability on a shipper for an injury that occurred at a location over which it had no control.[93]

VII. FEE SCHEDULE

In *Smart Document Solutions, LLC v. Hall*,[94] a photocopying service filed suit against the State Board of Workers' Compensation and several board members, asking that the superior court provide guidance in addressing the fees the company could charge for the photocopying of medical records.[95] Smart Document Solutions requested that the Board, which had established a fee schedule for photocopies, be required

86. *Axson Timber*, 286 Ga. App. at 482-83, 649 S.E.2d at 610.

87. *Id.* at 483, 649 S.E.2d at 611; Am. Mut. Liab. Ins. Co. v. Fuller, 123 Ga. App. 585, 586-88, 181 S.E.2d 876, 878 (1971).

88. Gramling v. Sunshine Biscuits, Inc., 162 Ga. App. 863, 864, 292 S.E.2d 539, 541 (1982).

89. *Axson Timber*, 286 Ga. App. at 483, 649 S.E.2d at 611.

90. 162 Ga. App. 863, 292 S.E.2d 539 (1982).

91. *Axson Timber*, 286 Ga. App. at 483, 649 S.E.2d at 611.

92. O.C.G.A. §§ 34-9-1 to -421 (2008).

93. *Axson Timber*, 286 Ga. App. at 484, 649 S.E.2d at 611.

94. 290 Ga. App. 483, 659 S.E.2d 838 (2008).

95. *Id.* at 483, 659 S.E.2d at 839.

to follow the guidelines established in the Health Records Act,[96] under O.C.G.A. § 31-33-3(a),[97] which would have provided higher rates to Smart Document Solutions for photocopies in workers' compensation cases.[98]

The Board filed a motion to dismiss the complaint for failure to state a claim upon which relief could be granted, and the superior court granted the motion,[99] agreeing with the Board that O.C.G.A. § 31-33-3(a) exempts from its guidelines "'records requested in order to make or complete an application for a disability benefits program.'"[100] Because workers' compensation benefits qualified as a disability benefits program, the superior court determined that copying records for workers' compensation claims was exempt.[101] The Georgia Court of Appeals agreed, noting that the Board had the regulatory authority to set photocopying fees in its own cases.[102] Thus, Smart Document Solutions' fees in workers' compensation cases fell within the authority of the Board.[103]

VIII. ATTORNEY FEES

In *L&S Construction v. Lopez*,[104] an employee filed a claim against a subcontractor and a general contractor. The employee was a construction worker, and he was found to be an employee of L&S Construction (L&S), which had been hired by St. John Construction, a general contractor, to frame a house.[105] The ALJ found that the worker was an employee for the subcontractor, L&S, on the day he was injured and awarded assessed fees to the employee and St. John to be paid by L&S under O.C.G.A. § 34-9-108,[106] which allows for assessed fees "'[u]pon a determination that proceedings have been brought, prosecuted, or defended in whole or in part without reasonable grounds.'"[107]

The subcontractor and its insurer appealed, pointing out that there was evidence before the ALJ which showed Lopez was not employed by

96. O.C.G.A. §§ 31-33-1 to -8 (2006).
97. O.C.G.A. § 31-33-3(a) (2006).
98. *Smart Document Solutions*, 290 Ga. App. at 483-84, 659 S.E.2d at 839-40.
99. *Id.* at 483, 659 S.E.2d at 839.
100. *Id.* at 484, 659 S.E.2d at 840 (quoting O.C.G.A. § 31-33-3(a)).
101. *Id.*
102. *Id.* at 485, 659 S.E.2d at 840.
103. *Id.*, 659 S.E.2d at 840-41.
104. 290 Ga. App. 611, 660 S.E.2d 1 (2007).
105. *Id.* at 611, 660 S.E.2d at 1.
106. *Id.*, 660 S.E.2d at 2; O.C.G.A. § 34-9-108 (2008).
107. *L&S Constr.*, 290 Ga. App. at 612, 660 S.E.2d at 2 (quoting O.C.G.A. § 34-9-108(b)(1)).

L&S on the day of the injury. L&S argued that it provided evidence that Lopez was working for the father of L&S's owner on that day, and the father did not have insurance. If this set of facts had been accepted by the ALJ, then St. John may have been found liable as a statutory employer. L&S argued to the Appellate Division that while this evidence did not ultimately win the case for it, this set of facts provided evidence that a reasonable dispute existed as to who employed Lopez on the day of the injury, and thus the award of assessed fees against L&S was improper. The Appellate Division agreed, and reversed the award of fees.[108]

The superior court then heard the case and reinstated the award of attorney fees.[109] Thus, L&S appealed to the Georgia Court of Appeals, which reinstated the Appellate Division's award, stating that the superior court erred in substituting its own factual findings for that of the Appellate Division.[110] This decision reiterates the premise that even if a defense is not ultimately successful, the issue of reasonableness (and the imposition of assessed fees) should be determined on the facts presented, rather than the outcome of the case.

IX. DEATH BENEFITS

In a case involving death benefits, *Sherman Concrete Pipe Co. v. Chinn*,[111] the issue was whether a 1989 version of O.C.G.A. § 34-9-13[112] contained an unconstitutional substantive change to the statute that affected the rights of a widow to receive benefits.[113] Ruby Chinn's husband died on January 16, 1990 in a work-related accident.[114] At the time, O.C.G.A. § 34-9-13, which had been amended in 1989, provided that dependency of a spouse "'shall terminate at age 65 or after payment of 400 weeks of benefits, *whichever occurs first*.'"[115] However, prior to 1989, the statute provided that dependency "'shall terminate at age 65 or after payment of 400 weeks of benefits, *whichever is greater*.'"[116] The widow pointed out that effective July 1, 1990, the statute was amended to again state that the dependency of a spouse "'shall

108. *Id.*, 660 S.E.2d at 2-3.
109. *Id.* at 611, 660 S.E.2d at 2.
110. *Id.*
111. 283 Ga. 468, 660 S.E.2d 368 (2008).
112. 1989 Ga. Laws 14.
113. *Chinn*, 283 Ga. at 468-69, 660 S.E.2d at 369.
114. *Id.* at 468, 660 S.E.2d at 369.
115. *Id.*, 660 S.E.2d at 369 (quoting 1989 Ga. Laws 14 § 34).
116. *Id.* (quoting O.C.G.A. § 34-9-13(e) (1988)).

terminate at age 65 or after payment of 400 weeks of benefits, *whichever provides greater benefits*.'"[117]

The widow was paid for thirteen years, and when the Georgia Insolvency Pool began handling the case, it terminated her dependency benefits, stating that she had actually been overpaid well beyond the 400 weeks, citing the "whichever occurs first" language of the statute in effect on the date of her husband's death on January 16, 1989.[118] The widow filed for reinstatement of the benefits, arguing that the version of the statute in effect in 1989 was unconstitutional because when amended, it contained and created a substantive change of law in violation of a provision of the Georgia constitution, which states that "'no bill shall pass which refers to more than one subject matter or contains matter different from what is expressed in the title thereof.'"[119]

The widow argued that the title and purpose of the 1989 Act (House Bill No. 93) simply referenced making "corrections" and that it was a "reenactment"[120] of laws already in existence. She argued that the title did not describe the 1989 act as making substantive changes in the law and thus argued that when the law was changed from the prior version, the law violated Georgia constitutional requirements that the title must state any substantive changes the new law contained.[121]

The ALJ and the Appellate Division ruled for the insurer, but the superior court reversed the Board, agreeing with the widow. The Georgia Supreme Court took the case to determine if the superior court's ruling that the 1989 statute was unconstitutional was correct.[122] The supreme court agreed with the superior court, finding that the legislature in 1989 had determined that changes were being made simply to

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117. *Id.* (quoting O.C.G.A. § 34-9-13(e) (1990)).

118. *Id.*

119. *Id.* at 468-69, 660 S.E.2d at 369 (quoting GA. CONST. art. III, § V, para. 3).

120. *Id.*, 660 S.E.2d at 369-70 (quoting 1989 Ga. Laws 14 at 14). The purpose of the Act was stated as follows:

> To amend the Official Code of Georgia Annotated, so as to correct typographical, stylistic, capitalization, punctuation, and other errors and omissions in the Official Code of Georgia Annotated and in Acts of the General Assembly amending the Official Code of Georgia Annotated; to reenact the statutory portion of the Official Code of Georgia Annotated as amended; to provide for necessary or appropriate revisions and modernizations of matters contained in the Official Code of Georgia Annotated; to provide for and to correct citations in the Official Code of Georgia Annotated and other codes and laws of the state; to provide for other matters relating to the Official Code of Georgia Annotated; to provide an effective date; to repeal conflicting laws; and for other purposes.

1989 Ga. Laws at 14.

121. *Chinn*, 283 Ga. at 468-69, 660 S.E.2d at 369-70.

122. *Id.* at 469, 660 S.E.2d at 370.

"correct grammatical errors and modernize language," essentially housekeeping measures, and the title of the act never put any legislator on notice that the act contained major substantive changes in the law.[123] Because the alteration of O.C.G.A. § 34-9-13(e) greatly limited the availability of benefits to the surviving spouse, the change violated the 1983 Georgia constitutional provision requiring that substantive changes be reflected in the act's title.[124]

X. OVERPAYMENT/REIMBURSEMENT

In *Renu Thrift Store, Inc. v. Figueroa*,[125] an employer determined that it had been paying benefits to an employee at a substantially higher rate than was actually due. The employer had paid benefits from September 2000 to March 2005, almost five years, before it figured out its own mistake. The employer immediately suspended the employee's benefits and then filed for a credit for the overpayment. The employee in turn filed for reinstatement of his benefits, argued that the employer was not entitled to a credit for the full five years of overpayments, and sought penalties and attorney fees as well.[126]

The ALJ found that O.C.G.A. § 34-9-245,[127] which limits a claim for reimbursement to two years from the date that it is applied for, was applicable to the case.[128] The employer did not have a right to the full five years of overpayments, although it argued that language found in O.C.G.A. § 34-9-243(a)[129] was applicable because the five years of overpayments were made "when not due," and there is no statute of limitation in O.C.G.A. § 34-9-243[130] to prevent a recovery of payments made "when not due."[131] The Georgia Court of Appeals agreed with the ALJ and stated that the language of O.C.G.A. § 34-9-243 did not provide a method of ignoring the "natural and most obvious import" of O.C.G.A. § 34-9-245, as its very purpose was to provide certainty of knowing that past payments are not subject to reimbursement after two years.[132]

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123. *Id.* at 469-70, 660 S.E.2d at 370.
124. *Id.* at 470, 660 S.E.2d at 370.
125. 286 Ga. App. 455, 649 S.E.2d 528 (2007).
126. *Id.* at 455-57, 649 S.E.2d at 529-30.
127. O.C.G.A. 34-9-245 (2008).
128. *Renu Thrift Store*, 286 Ga. App. at 456-57, 649 S.E.2d at 530.
129. O.C.G.A. 34-9-243(a) (2008).
130. O.C.G.A. 34-9-243 (2008).
131. *Renu Thrift Store*, 286 Ga. App. at 457-58, 649 S.E.2d at 530-31 (quoting O.C.G.A. 34-9-243(a)).
132. *Id.* at 458, 649 S.E.2d at 530-31 (quoting Trax-Fax, Inc. v. Hobba, 277 Ga. App. 464, 466, 627 S.E.2d 90, 93 (2006)).

Unfortunately for the employer, the employee went on to claim that over that five years the employer had not paid him weekly, as required by O.C.G.A. § 34-9-221(b).[133] The employer had not asked for a special exception to pay bi-weekly, which is what it had actually done. Even though the employer argued that the bi-weekly checks actually contained one early week and one timely week of benefits, the Board penalized the employer by assessing a fifteen percent penalty against it for failing to follow the letter of the law, which requires that payments must be made in weekly installments.[134]

Even more unfortunately for the employer, the employee also claimed and was awarded assessed fees for the employer's unilateral suspension of benefits after it discovered the overpayment, as it had no right to suspend benefits on that basis, especially when the overpayment was due to its own error. The ALJ awarded the employee the assessed fees based on an improper suspension of the weekly benefits.[135] The court of appeals affirmed the ALJ's ruling in its entirety.[136]

XI. SECONDARY PAYER ACT/MEDICARE SET ASIDE TRUSTS

Georgia's Workers' Compensation Act,[137] like those of all the states, is a creation of its legislature, and as a result is generally changed only through amendments to the Act or interpretations by the Georgia Court of Appeals and Georgia Supreme Court. Very little legislation or caselaw, however, has impacted workers' compensation in Georgia and across the country as significantly as a federal statute known as the Secondary Payer Act.[138] This legislation, though passed in the 1980s, has made an increasingly significant impact in the workers' compensation system since Medicare and the Centers for Medicare and Medicaid Services (CMS), which administers Medicare, have become more aggressive in utilizing the Secondary Payer Act's provisions. Unfortunately, CMS has utilized its authority to force the creation of so-called "Medicare Set Aside Trusts" (MSAs) that significantly impede the settlement of the most serious, and expensive, of workers' compensation claims. In the process, these regulations have also created a large and complicated bureaucracy that must be negotiated if all parties to a workers' compensation settlement are to feel safe from potential suit by

133. *Id.* at 457, 649 S.E.2d at 530; O.C.G.A. § 34-9-221(b) (2008).
134. *Renu Thrift Store*, 286 Ga. App. at 457, 458-59, 649 S.E.2d at 530, 531.
135. *Id.* at 459, 649 S.E.2d at 531.
136. *Id.*
137. O.C.G.A. §§ 34-9-1 to -421 (2008).
138. 42 U.S.C. § 1395y(b) (2000 & Supp. V 2005).

the federal government for failing to take Medicare's interests sufficiently into account.

The manner in which CMS has interpreted its responsibilities to protect Medicare from inappropriate cost-shifting reflects the fundamental lack of comprehension that exists between the worlds of Medicare and workers' compensation and has resulted in a very large, and perhaps unnecessary, infusion of cost into the workers' compensation system.

A. The Secondary Payer Act

Medicare was originally established by Congress as a federally funded form of limited medical care for those age sixty-five or older, as well as those who have been entitled to receive Social Security Disability Insurance benefits for more than two years.[139] By the 1980s, it was clear that the funding mechanisms originally established to fund Medicare were insufficient, and with the ever expanding "baby boomer" generation, Medicare faced a developing financial crisis. It was in this context that Congress passed the Secondary Payer Act, which established the principle that Medicare's coverage should only be secondary to any other primary coverage, including workers' compensation, that might be available.[140]

Undeniably, Medicare incurs substantial costs that are shifted to it through the settlement of workers' compensation claims, which historically did not provide for the claimant's future medical treatment other than to provide a lump sum of money as consideration to be spent at the claimant's discretion. While the Secondary Payer Act provides that Medicare's interest should be reasonably taken into account, nothing within the statute specifically prevents a claimant from later seeking payment for medical treatment under Medicare that might have been covered by workers' compensation, and might, or might not, have been fully funded in the workers' compensation settlement.[141]

It was not until the late 1990s that Medicare and CMS acted to utilize the Secondary Payer Act as a means of confronting the cost-shifting issue. In 2001, CMS instructed its regional offices, through the so-called "Patel memo,"[142] that CMS should review certain workers' compensa-

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139. *See* United States v. Baxter Int'l, Inc., 345 F.3d 866 (11th Cir. 2003).

140. *See* 42 U.S.C. § 1395y(b).

141. *See id.*

142. Memorandum from Parashar B. Patel, Deputy Director, CMS Purchasing Policy Group, Center for Medicare Management to all Associate Regional Administrators, "Workers' Compensation Commutation of Future Benefits" (July 23, 2001), *available at* www.cms.hhs.gov/workerscompagencyservices/downloads/72301memo.pdf.

tion settlements to approve the allocation of future medical expenses and to ensure that Medicare's interests were being suitably protected.[143] It is the criteria and methodology created by CMS for Medicare's protection that has caused enormous repercussions in the workers' compensation system.

B. Medicare Set Aside Trusts and CMS Preapproval

The mechanism established by CMS to protect Medicare's interests first establishes a criteria for which workers' compensation settlements are subject to CMS review and then requires the establishment of a "set-aside" or "Medicare set-aside" trust (MSA) for those cases.[144] The criteria originally established by CMS for its review was (1) any workers' compensation claim in which the claimant is already a recipient of Medicare or (2) cases in which the injured individual has a "reasonable expectation" of Medicare entitlement within thirty months of the settlement *and* the settlement is over $250,000.[145] In subsequent memoranda, CMS has attempted to clarify what is meant by a "reasonable expectation" that a claimant would become entitled to Medicare within thirty months.[146] CMS considers such a "reasonable expectation" to exist if the claimant has merely applied for Social Security Disability Benefits, has been denied benefits but plans on appealing that decision, or is in the process of refiling for benefits.[147]

If a workers' compensation claimant meets either of the criteria established by CMS, a MSA must be included as part of the workers' compensation settlement and submitted for review by CMS. CMS will then either approve the MSA or reject it and recommend a higher dollar figure for the MSA. Although neither the Secondary Payer Act nor any published federal regulation specifically requires either MSAs or their approval by Medicare, CMS has made it clear through its published memoranda that failure to obtain CMS approval of an MSA exposes all parties connected to the settlement to the Secondary Payer Act's civil liability for double damages.[148]

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143. *See id.*

144. *See id.*

145. *Id.* at Answer 1. These limits have since been amended to exclude claims in which the claimant is Medicare eligible but the settlement is less than $25,000.

146. *Id.*

147. *Id.* at Question 2.

148. Memorandum from Gerald Walters, Director, CMS Financial Services Group, Office of Financial Management to all Regional Administrators, "Medicare, Secondary Payer (MSP) - Workers' Compensation (WC), Additional Frequently Asked Questions," Question & Answer Number 2 (July 11, 2005), *available at* www.cms.hhs.gov/workerscompagencyservices/downloads/71105memo.pdf; *see* 42 U.S.C. § 1395(b)(3) (2000 & Supp.

C. CMS Requirements for MSA Amounts

In attempting to reasonably protect Medicare's interests in the settlement of workers' compensation claims, CMS has indicated that MSA amounts should include future medical costs based on life expectancy, the claimant's past course of medical treatment, the claimant's current condition, and other factors.[149] Neither CMS nor Medicare, however, have published any specific guidelines for the calculation of a correct MSA amount, and as a result, the standards are both vague and in practice seem to encompass virtually any *potential* medical expense that Medicare might eventually have to pay, without regard to the probability of the expense being incurred. In addition, even if the parties attempt to annuitize or calculate the present-day value of medical expenses that might spread across decades, CMS requires that "seed money" be calculated to cover the first two years of medical expenses from the date of the settlement, presumably to cover the period of time that CMS may need to review their proposed MSA.[150] In the most serious of workers' compensation cases, and especially those involving catastrophic injuries,[151] MSAs as required by CMS are frequently in the hundreds of thousands of dollars and in many instances are so large as to preclude any financial incentive for the parties to settle. As a result, many claims continue on the periodic payment structure required under the Workers' Compensation Act, inhibiting a claimant's ability to settle and expanding both future risk and reserve obligations for workers' compensation insurers and self-insured employers.

It is interesting to consider how Medicare's cost-shifting problems might be viewed if it was a private entity, as opposed to a part of the federal government. Assume, for example, that a large group health insurer attempted to intervene in a workers' compensation claim seeking protection because the claimant's spouse was an insured under one of its group insurance plans and therefore might potentially seek coverage under the group plan for the claimant's future medical needs. No one would dispute that such a group carrier would lack any standing to force

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149. *See* Memorandum of Patel, *supra* note 143.

150. Memorandum from Gerald Walters, Director, CMS Financial Services Group, Office of Financial Management to all Regional Administrators, "Medicare Secondary Payer (MSP) - Workers' Compensation (WC) Additional Frequently Asked Questions" Question 5 (October 15, 2004), *available at* www.cms.hhs.gov/workerscompagencyservices/dowloads/101504memo.pdf.

151. O.C.G.A. § 34-9-200.1 (2008).

the parties to the workers' compensation settlement to make any provision for the group carrier's protection from unspecified, potential payments. On the contrary, the group carrier's remedy would be to simply amend its policy to exclude coverage for other forms of insurance. While Congress did this with the passage of the Secondary Payer Act over two decades ago, Medicare and CMS have taken the provisions of this law and, with the power of the federal government, required all parties to a workers' compensation case to use CMS's notions of what is required to protect Medicare, even if there is only a potential for the claimant to seek coverage from Medicare at some point in the future. Moreover, CMS's standards for calculating the amount of an MSA clearly assume the worst possible future medical expense, in order to provide the most expansive protection for Medicare.[152]

While no one would dispute that Medicare's financial condition and simple equity require that Medicare be protected from what has undoubtedly been significant cost-shifting practices in the settlement of workers' compensation claims, the mechanism that has emerged is expensive, overly complex, and has arguably done very little to eliminate the very cost-shifting dilemma it seeks to prevent.

D. Self-administration of MSAs

Most, if not all, MSAs are self-administered by the claimant. As a practical matter, claimants do not wish to have this substantial amount of money directed by a third party, and CMS does not currently have any prohibition on the MSA being directly administered by the claimant. While CMS does have regulations regarding documenting MSA expenditures, there is very little evidence to demonstrate that claimants are abiding by these requirements or that they are able to present such documentation to Medicare to show that the MSA has been exhausted before seeking additional coverage from Medicare.

A 2008 CMS form states that the claimant is responsible for keeping accurate records of all MSA account activity when the claimant is self-administering the trust and further reserves the right for CMS to audit how MSA funds were spent.[153] If CMS determines that the MSA was used to pay for anything other than allowable medical expenses, Medicare will not provide coverage for any work-related medical

152. *See* Memorandum of Patel, *supra* note 143.

153. Administering your lump sum Workers' Compensation Medicare Set Aside Treatment (WCMSA), standardized form attachment mailed with CMS review correspondence, CMS (2008).

expenses until the MSA funds are restored and properly exhausted.[154] The system constructed by CMS, therefore, relies upon claimants to self-administer their expenditures from the MSA account and assumes that claimants will be able to present a proper accounting of MSA expenditures before seeking future coverage from Medicare.[155] Virtually all practitioners agree, however, that claimants are not properly documenting their MSA expenditures and will be unable to present sufficient documentation to Medicare when they seek coverage in the future. If true, then the elaborate mechanism created by CMS to protect Medicare's interests in the settlement of workers' compensation claims will be ineffective.

E. Court Challenges to CMS Requirements

There are relatively few reported cases dealing with the Secondary Payer Act, and specifically whether CMS has authority to intervene in workers' compensation cases to require the establishment of MSAs in the manner it has dictated. In *Protocols LLC v. Leavitt*,[156] Protocols, a company that provides Medicare Set Aside Analysis, challenged CMS guidelines regarding the establishment of MSAs, claiming, among other things, that CMS reviews are "arbitrary and capricious" and do not allow for due process in the form of any appeal or review from a CMS determination.[157]

Protocols' claims were never addressed, however, because the court found that Protocols lacked standing to bring its claims.[158] While the parties to the case apparently agreed to stipulations regarding CMS methodology, the plaintiffs failed to present any evidence of an actual case in which Medicare or CMS reviewed a proposed set aside in a way that was arbitrary, capricious, or violative of the Secondary Payer Act.[159]

Similarly, in *Miller v. Workers' Compensation Appeal Board*,[160] claims against the authority of CMS to require Medicare set asides were not reached because the court concluded that the parties to the workers' compensation settlement had not reached a meeting of the minds on the

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154. *See* Terms and Conditions for Beneficiary Administered Workers' Compensation Medicare Set Aside arrangement (WCMSA), CMS (April 2005), *available at* www.cms.hhs.gov/workerscompagencyservices/downloads/samplesubmission.pdf.

155. *See id.*

156. No. 05-cv-01492-BNB-PAC, 2007 U.S. Dist. LEXIS 16659 (D. Colo. Mar. 7, 2007).

157. *Id.* at *10-*11.

158. *Id.* at *19-*20.

159. *Id.* at *18, *19-*20.

160. 940 A.2d 603 (Pa. 2008).

specific terms of the settlement agreement.[161] While the merits of these particular cases have not been reached, the arguments regarding the standing of Medicare and CMS to impose the MSA structure on workers' compensation claims remain, and it is far from certain that the mechanism chosen by CMS would meet even minimal constitutional requirements for due process and reasonableness. It also remains to be seen, however, whether a case will arise in which a party deems it financially viable to pursue such claims against the federal government.

F. Proposed Legislation

Perhaps recognizing that relief through the court system may not be financially viable, efforts have been made with the support of various groups within the workers' compensation system to seek a legislative remedy. A bill introduced in the United States House of Representatives by Representatives John Tanner (D-TN) and Phil English (R-PA) would exempt workers' compensation cases with a present value of less than $250,000 when the claimant is likely to be ineligible for Medicare, not likely to have future medical expenses related to the work-related injury, or in the case of certain compromise agreements.[162] The American Bar Association has expressed its support of this legislation,[163] and at this writing, the bill has been referred to the House Subcommittee on Health.

It is without question that CMS's requirements regarding all MSAs and the protection of Medicare's interests have created a substantial impediment to the most serious of workers' compensation claims and have infused a significant amount of additional expense into workers' compensation systems across the country. New CMS regulations also propose to create an additional mechanism that would require workers' compensation insurers and others to report electronically on a quarterly basis any and all claims to CMS in which the claimant is a recipient of Medicare, along with information regarding the status of the individual's workers' compensation claim.[164] Although as of this writing CMS has not indicated how workers' compensation insurers are to accurately determine whether or not a claimant is on Medicare, the cost of violating

161. *Id.* at 609.

162. H.R. 2549, 110th Cong. (2007).

163. Memo from Legislative and Governmental Advocacy Governmental Affairs Office, American Bar Association, *available at* www.abanet.org/poladv/priorities/medicaresetaside.

164. Supporting Statement for the Medicare Secondary Payer Mandatory Insurer Reporting Requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), *available at* www.cms.hhs.gov/mandatoryinsrep/downloads/supporting statement082808.pdf.

these new reporting requirements is $1000 per day per claimant.[165] As Medicare and CMS continue to find ways to ensure that Medicare's interests are protected, it appears evident that more, rather than less, intrusion will incur into the workers' compensation system. Practitioners should continue to be aware of the ever-changing MSA landscape and support efforts being made in Congress to find a more workable solution than the current MSA bureaucracy.

165. *Id.*