RICHTER HEAD

Georgia Workers' Compensation Quick Reference Guide

COMMONLY USED BOARD FORMS

Form	Form Name	Form Purpose	Deadlines	Other Information
WC-1	First Report of Injury	Reports injury to Board. Can use to commence benefits, controvert benefits, or designate claim as medical only.	File within 21 days of E/I's knowledge of accident.	Contents of the WC-1 in Section A are not admissible in hearings. Board can penalize if not timely filed.
WC-2	Notice of Payment/ Suspension of Benefits	Gives notice to all parties of a benefit suspension/modification/commencement.	Employer/Insurer must file and serve at the time benefits are commenced/suspended/modified.	The form must have attached any medical reports used to suspend benefits.
WC-3	Notice to Controvert	Deny entire or any part of a claim.	Must be filed within 21 days of the initial claim, or 81 days if the claim was initially accepted.	Failure to timely file can result in fees/penalties. If a WC-1 is already filed, use a WC-3 to deny claim in part/whole.
WC-4	Case Progress Report	Demonstrates total payouts in claim.	Within first 180 days of compensability, every 12 months thereafter, and 30 days after file closure.	Board can penalize if not timely filed.
WC-6	Wage Statement	Demonstrates Employer/Insurer's AWW calculations.	Should be filed when paying less than max TTD rate, when requested by Board, or prior to hearing.	Must be on file if paying income benefits at rate less than max.
WC-14	Notice of Claim/Request for Hearing/Mediation	Allows parties to request a hearing/mediation, or to file a Notice of Claim to toll statute of limitations.	Party must file WC-14 within 1 year from the DOI, with some exceptions. O.C.G.A. § 34-9-82.	Claim is barred by the statute of limitations if no benefits provided, and no WC-14 is filed within 1 year.
WC-25	Request for Advance	To request advance payment of income benefits.	15 days to file a response.	Filed by Claimant.
WC-102	Request for Documents	To request documents from a party.	30 days to respond.	Claimant usually serves in claims not in litigation. Can be penalized if untimely response.
WC-102d	Motion/Objection	Request Board action without a hearing.	15 days to file a response.	Motions are likely granted if no response is filed. Send file to defense.
WC-104	Notice of Release to Return to Work	Can reduce TTD to lower TPD rate and caps income benefits at 350 weeks (see other side).	File a WC-104 within 60 days of the Claimant being released to light-duty work and attach the medical report.	Invalid if it does not include the medical report from the ATP. Reduce benefits from TTD to TPD after 52 consecutive or 78 aggregate weeks of light duty. File a WC-2 when reducing rate.
WC-200a	Change of Physician/Add'l Treatment by Consent	Notes a change of physician or authorization of additional medical treatment.	No Deadline. Filed by agreement.	Recommend filing to denote the Claimant's statutory one-time change.
WC-200b	Request/Objection to Change in Physician	Change ATP or obtain treatment when parties.	15 days to file a response.	Use WC-200a if all parties agree to physician.
WC-205	Request for Preauthorized Medical	Used by physicians to obtain quick approval or denial of medical treatment.	Must respond within 5 business days.	If response is untimely, treatment is approved.
WC-243	Credit	Request credit pursuant to O.C.G.A. § 34-9-243 for employer-funded portions of benefits received by employee pursuant to unemployment plan, disability plan, wage continuation plan, or disability insurance policy.	Must file at least 10 days prior to a hearing.	Only receive credit for those portions funded by the employer.
WC-262	Wage Documentation (TPD)	Document TPD payments when paying below maximum.	File at 13-week intervals or when TPD is suspended.	Used when Claimant has returned to work earning less than AWW.
WC-PMT	Petition to Show Cause Regarding Medical Treatment	Used by Claimant to request show cause conference call with ALJ regarding the authorization of medical treatment.	To cancel call, (1) authorize treatment or (2) controvert. Failure to authorize or controvert will result in show cause call with ALJ where ALJ can issue interlocutory order on medical treatment. Object to order by filing WC-14 RFH.	Claimant must have provided request to Employer/Insurer at least 5 business days before filing WC-PMT. If filing controvert, Claimant can request hearing to adjudicate the issue. A party objecting to interlocutory order may request hearing within 20 days, which supersedes interlocutory order.
WC-PMT(b)	Petition for Failure to Attend Medical Appointment with an ATP	Filed by Employer/Insurer when Claimant fails to attend medical appointments with ATP or treatment recommended by ATP.	Can only be filed after Claimant fails to attend medical appointment.	Parties can agree for Claimant to attend appointment and cancel telephonic show-cause conference. If, after interlocutory order from Board, Claimant still does not attend, Employer/Insurer must file another WC-PMT(b) requesting Claimant to show cause why benefits should not be suspended.
WC-R1CATEE	Request for Catastrophic Designation	Filed by Claimant to request catastrophic designation (O.C.G.A. § 34-9-200.1).	Must file WC-Rehab Objection and WC-14 Request for Hearing seeking ALJ to adjudicate issues within 20 days of filing.	Must object within 20 days or Rehab Division will issue opinion on catastrophic designation request. Catastrophic designation = lifetime medical and income benefits if injury prevents Claimant from finding work available within substantial numbers within the national economy, amputation of arm, hand, leg, or foot, spinal cord injury, brain or closed head injury, 2nd or 3rd degree burns to over 25% of the body, or total/industrial blindness.

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COMPENSATION RATE

The compensation rate is equal to two-thirds of the AWW.

TABLE OF BENEFIT RATES*		
DOI (on or after)	Weekly TTD	Weekly TPD
7/1/2013	Max: $525.00	Max: $350.00
7/1/2015	Max: $550.00	Max: $367.00
7/1/2016	Max: $575.00	Max: $383.00
7/1/2019	Max: $675.00	Max: $450.00
7/1/2022	Max: $725.00	Max: $483.00
7/1/2023	Max: $800.00	Max: $533.00

*See O.C.G.A. § 34-9-261 legislative history for maximum rates before 7/1/2013. Minimum rate = $50.

TTD BENEFITS

- Only due after Claimant has missed 7 days of work due to a medical disability provided by the ATP. O.C.G.A. §. 34-9-220
- 7-day waiting period is recoverable after Claimant has missed 21 consecutive days. BR 220

PPD BENEFITS

Calculated using PPD ratings from the *AMA Guides to the Evaluation of Permanent Impairment, 5th Edition.*

Scheduled Members (PPD Benefits)	
Body Part (Member)	Maximum Weeks
Body as a Whole	300 weeks
Arm	225 weeks
Leg	225 weeks
Hand	160 weeks
Foot	135 weeks
Thumb	60 weeks
Index Finger	40 weeks
Middle Finger	35 weeks
Ring Finger	30 weeks
Little Finger	25 weeks
Great Toe	30 weeks
Other Toes	20 weeks
Loss of Hearing: One Ear	75 weeks
Loss of Hearing: Both	150 weeks
Loss of Vision (One Eye)	150 weeks

DEATH BENEFITS

DOI (on or after)	Cap
7/1/2019	$270,000
7/1/2022	$290,000
7/1/2023	$320,000

PAYMENT OF BENEFITS (O.C.G.A. § 34-9-221)

Without an Award – must be paid when due or face 15% late payment penalty.
With an Award – must be paid within 20 days (in state) or 17 days (out of state) or face 20% penalty.

THE WC-240 PROCESS (Returning Claimant to Work)

1. Obtain a job description with physical requirements from the Employer.
2. Send job description to ATP for approval, sending to Claimant and Claimant's attorney at same time.
3. Send WC-240 with job description approved by ATP to Claimant and Claimant's attorney providing minimum 10 days' notice of start date.
4. If Claimant does not show up for the job, suspend benefits by filing WC-2 and attach WC-240.
5. If Claimant attempts the offered job for 8 total hours or 1 scheduled workday (whichever is longer), and Claimant is unable to perform the job for more than 15 days, weekly income benefits must be **reinstated immediately**. E/I can file hearing request seeking suspension based on unjustifiable refusal of suitable light-duty work and file Motion to Suspend.
6. If Claimant works for more than 15 days and then stops, E/I does not need to reinstate income benefits without court order and burden shifts to Claimant to prove job was not suitable.

CONVERTING TTD TO TPD (WC-104)

- File and send WC-104 to Claimant and attorney within 60 days of light-duty work release with medical attached.
- After Claimant has been on work restrictions for 52 consecutive or 78 aggregate weeks, file WC-2 suspending TTD benefits and commencing TPD.
- Maximum entitlement to indemnity benefits reduced from 400 to 350 weeks from DOI

MEDICARE SET-ASIDES

- If Claimant is Medicare beneficiary, CMS ***recommends*** submission of an MSA for claims that settle for $25,000 or more.
- If Claimant is NOT a Medicare beneficiary but is (1) receiving/applied for SSDI or (2) is at least 62.5 years old, you must consider Medicare's interests (e.g., obtain an MSA), but CMS only ***recommends*** seeking approval if total settlement is over $250,000.
- Very important to show that you have adequately considered Medicare's interests.
- Seeking CMS approval is a voluntary process and is not required by CMS guidelines, only recommended.

DENYING "ALL ISSUES" CLAIMS*

Denial Reasons:

1. **No accident or injury** arising out of or occurring in the course and scope of the employment. O.C.G.A. § 34-9-1(4)
2. **No employer/employee relationship**.
3. The Claimant's injury was caused by **intoxication/ horseplay/willful misconduct**. O.C.G.A. § 34-9-17.
4. The injury was **idiopathic**, and the Claimant was injured due to a personal medical condition or unexplained fall.
5. The Claimant failed to provide the Employer with **notice** of the accident as required by O.C.G.A. § 34-9-80.
6. The Claimant's right to compensation is barred by the **Statute of Limitations**. O.C.G.A. § 34-9-82(a) or O.C.G.A. § 34-9-104.
7. The Claimant intentionally misrepresented their physical condition, and their claim is therefore barred by the ***Rycroft*** defense.

For ALL DENIED Claims:
ALWAYS include "Employer/Insurer reserve the right to assert any and all defenses under O.C.G.A. § 34-9."

DENYING MEDICAL TREATMENT ONLY*

Denial Reasons (use form WC-3):

1. Requested treatment is not medically necessary or causally related to the injury.
2. Requested treatment is not likely to effect a cure, give relief, or restore the Claimant to suitable employment.
3. Requested treatment is not from ATP.

DENYING DISABILITY ONLY*

Denial Reasons (use form WC-1 or WC-3):

1. No medical evidence from authorized provider that Claimant sustained disability over 7 days.
2. Disability unrelated to work injury.
3. Claimant has unjustifiably refused suitable light-duty work (See WC-240).

*__Note__ that these lists are not exhaustive. There may be additional reasons to deny a claim based on specific facts. Always refer to the Georgia statutes and Board rules or consult with one of our attorneys.

MISCELLANEOUS INFORMATION

MILEAGE REIMBURSEMENT
O.C.G.A. § 34-9-203(c) & BR 203(e)

- $0.45 per mile
- Must be submitted within 1 year of date of service.
- Must be paid within 15 days.
- Late payments after 30 days. BR 203(c)(3)

400-WEEK CAP ON MEDICAL TREATMENT:

- All non-catastrophic injuries occurring on or after 7/1/13 are medically capped at 400 weeks of medical care with exception of maintenance of prosthetic, spinal cord stimulator, or durable medical equipment.

PAYMENT OF MEDICAL BILLS:

- Must be paid within 30 days, if in proper form.
- Bills submitted more than 1 year after service date are barred by the Statute of Limitations.

INDEPENDENT MEDICAL EXAMS (IME's):

- If requested by **Claimant**:
  - Must be within 120 days of receipt income benefits
  - Must provide notice of IME to the E/I
  - Pre-payment maximum of $1,200
  - Additional charges per fee schedule due within 30 days of receipt of report and charges by E/I.
  - Claimant is only entitled to one IME paid for by E/I.
- If requested by **Employer/Insurer** (BR 202):
  - Claimant must be given 10 days' notice.
  - Notice must include mileage prepayment.

SPECIFIC INJURIES

- **Heart Attack** – requires showing that the attack was attributable to the performance of employment.
- **Psychological Injury** – general rule is that these are not compensable absent a physical injury.
- **Hernia** – Claimant must show (a) there was an injury resulting in a hernia, (b) hernia appeared suddenly, (c) it was accompanied by pain, (d) it immediately followed an accident, and (e) it did not exist prior to the accident. O.C.G.A. § 34-9-266.

PANEL OF PHYSICIANS

- Must be posted in a prominent location before injury.
- Minimum 6 doctors (at least 1 orthopedic surgeon & minority physician)
- Maximum 2 industrial clinics allowed on a Panel.
- If Employer fails to have valid Panel, the Claimant may select any physician at E/I's expense.

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