ERACLIDES GAZETTE

Navigating the WC-240 Process in Georgia

By: Zachary Kunz, Associate, Atlanta

Georgia, unlike many other states, has a statutory procedure that must be strictly adhered to in order to return a claimant to work. It is one of the more frustrating issues in Georgia. In other states, you can simply send a letter to the claimant asking him to return to work so that benefits can be suspended. This cannot be farther from the procedure in Georgia.

The procedure used to suspend benefits a claimant's benefits is described in O.C.G.A. § 34-9-240 and Board Rule 240. The first step is to identify a suitable light duty position within the claimant's restrictions. Next, one must create a WC-240(a) Job Analysis or a light duty job description for the proposed position. The WC-240(a) Job Analysis or the light duty job description must then be sent to the Authorized Treating Physician (ATP) for approval and it must also be sent to the claimant and his attorney at the same time and in the same manner (email, fax, etc.). In order for the ATP's approval of the job description to be valid, the claimant must have been examined within the last 60 days.

Once the approved job description or WC-240(a) is approved by the ATP, it should be attached to the completed WC-240. The WC-240 should contain the claimant's proposed hours, rate of pay, job location, and start date. The WC-240 job offer and approved job description must then be sent to the claimant and his attorney to inform them that there is a suitable job available. Finally, you must provide the claimant with at least ten days notice before their return to work date.

If the claimant refuses to return to work pursuant to the WC-240 process, you can suspend the claimant's income benefits. To properly suspend benefits, you must file a WC-2 with the Board, pursuant to Board Rule 240(b)(3). The WC-240 notice, light duty job description and/or WC-240(a), and the approval from the authorized treating physician should be attached to the WC-2 Notice of Suspension of Benefits.

Sometimes a question arises as to whether the claimant has unjustifiably refused suitable employment when the claimant returns to work but is "unable" to perform the approved light duty job. This seems illogical, but if the claimant attempts the

job for at least one day or an eight hour shift (whichever is greater), but subsequently is unable to perform the job for more than fifteen scheduled work days, benefits must be immediately reinstated. However, the employer/insurer should file for a hearing requesting the Judge suspend the claimant's benefits. Also, anytime prior to the hearing a motion can be filed seeking an interlocutory order to suspend the claimant's weekly benefits pending the hearing.

Although the WC-240 process demands a great deal from the employer/insurer, and is at times frustrating, when properly implemented the process can be used effectively to unilaterally suspend the claimant's benefits. It effectively guarantees that the claimant must attempt the light duty job. Further, if the claimant asserts that he is "unable" to perform the job the employer/insurer has the opportunity to request a hearing and challenge this assertion. Regardless, this process usually moves the case toward closure.

Latest Pitfall with Florida's Medical Providers

By: Mary Frances Nelson, Partner, Fort Myers

In the ever-changing landscape of Florida workers' compensation, we often see a push by the claimants' bar to have the benefits pendulum swing back towards them. In a recent Miami decision, the JCC may have helped this to happen. In the case of Luis Rodriguez v. Demetech Corp., OJCC Case No. 14-028630SMS, Judge Medina-Shore ruled in favor of the claimant on his motion to de-authorize and strike the opinions of a treating provider, and permitted the claimant to select the replacement. **Please note this is not binding authority**, as it is only a JCC decision, and will likely be appealed to the First DCA. It is, however, our duty to inform you of possible problems with medical authorizations in the event you receive a similar motion.

In April 2015, the claimant requested a one-time change in physician. The carrier timely authorized Dr. Warren Grossman, and informed the claimant of the appointment. When getting the appointment set, the carrier signed an agreement with the doctor allowing for payment of treatment in excess of fee schedule. When the claimant realized the doctor was getting paid in excess of the fee schedule, this motion proceeded under the authority of FS 440.13(14)(a),(b). Based on the evidence, the JCC ruled that the doctor's receipt of fees in excess of those permitted by fee schedule was a violation of the statute, de-authorized the doctor, and struck any opinions associated with the treatment.

What should you take away? This may be yet another tactic from the claimant's bar to shift control of the medical back towards the claimant. Unfortunately, it may also backfire, as we are faced with increasingly limited options for physicians who will even accept workers' compensation patients, much less fee schedule. At this juncture, carriers are not bound by this ruling. Continue to handle medical authorizations as you have in the past. With that said, how can you protect yourself? FS 440.13(14)(b) permits a deviation from fee schedule if there is a written agreement between the doctor's office and the carrier that provides a procedure to provide quality medical care to the claimant. The statute references considerations such as scheduling timely appointments, helping with return-to-work programs, speeding up reports, agreeing to be subject to UR, per-certification, or case management. If there is a provider who demands in excess of fee schedule, and the carrier has to sign a contract, consider adding terms to support these sorts of benefits. It is not a guarantee, but does show that the carrier is attempting to comply with FS 440.13.

As always, our attorneys are glad to help with such concerns and issues.

Minimum Compensation Rates—They do Exist!

By: Michael Casto, Associate, Orlando

Every now and then I get a question about the minimum compensation rate in Florida. While the dollars may seem insignificant, fines from the state may be much worse if it is not calculated correctly. Additionally, when the Supreme Court makes a decision on claimant attorney fees in the pending Castellanos v. Next Door Company, et. al case, this may be a costly oversight.

The statutory section that covers the minimum compensation rate is § 440.12(2). It reads :

> [c]ompensation for disability resulting from injuries which occur after December 31, 1974, shall not be less than $20 per week. However, if the employee's wages at the time of injury are less than $20 per week, he or she shall receive his or her full weekly wages. If the employee's wages at the time of the injury exceed $20 per week, compensation shall not exceed an amount per week which is: (a) Equal to 100 percent of the statewide average weekly wage, determined as hereinafter provided for the year in which the injury occurred; however, the increase to 100 percent from 662/3 percent of the statewide average weekly wage shall apply only to injuries occurring on or after August 1, 1979; and (b) Adjusted to the nearest dollar.

The Legislature also added that "[f]or the purpose of this subsection, the "statewide average weekly wage" means the average weekly wage paid by employers subject to the Florida Reemployment Assistance Program Law as reported to the Department of Economic Opportunity for the four calendar quarters ending each June 30, which average weekly wage shall be determined by the Department of Economic Opportunity on or before November 30 of each year and shall be used in determining the maximum weekly compensation rate with respect to injuries occurring in the calendar year immediately following. The statewide average weekly wage determined by the Department of Economic Opportunity shall be reported annually to the Legislature."

This can be broken down into language that is much easier to digest. Essentially, in Florida, the minimum compensation rate only applies if your average weekly wage is greater than $20.00, and then subsequently calculating the temporary total or temporary partial disability rate takes you below $20.00. For example, if the AWW is $25.00, the temporary total disability formula would give you a weekly compensation rate of $16.68. In this instance you would round up and use the minimum compensation rate, $20.00.

If, on the other hand, the average weekly wage is $18.00 per week, you would use the actual earnings as the weekly compensation rate. Under this circumstance, the compensation rate would be $18.00. It would not be rounded up to $20.00.

If there are no earnings, such as a volunteer, the minimum compensation rate does not apply. You do not pay anything!

This also applies if the Claimant did not report his earnings for Federal income tax purposes. Recall that the compensation rate is calculated by using the Claimant's pre-accident wages. Section 440.02(28) defines "wages," in part, as monies earned and reported for Federal income tax purposes. Thus, if the Claimant did not report his earnings for Federal income purposes, the minimum compensation rate does not apply, because the average weekly wage is $0.00.