State of Georgia
Subsequent Injury Trust Fund

Guidelines for Claims Procedures & Evaluation

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PREFACE

This handbook is designed to inform insurance carriers, self-insurers, employers and employees about the Georgia Subsequent Injury Trust Fund (SITF) and to define the prerequisites and proper procedures for filing a claim with the fund. The information contained in this handbook is designed for informational purposes only and should not be construed to be legally binding. The rules and regulations, which govern the operations of the SITF, are printed in Appendix B.

As changes in Georgia state law may alter the statutes under which the fund operates, portions of the information in this handbook may be rendered inaccurate in the future. The handbook will be amended when changes in state legislation and fund rules and regulations necessitate revisions. However, it is not the responsibility of the fund to notify parties who have received the handbook of any future changes. The recipient must take full responsibility for securing current copies of the handbook.

This handbook has been written in question and answer format to provide easy access and understanding. A glossary of terms commonly used by the fund is provided at the end of this handbook.

Our Mission: The Georgia Subsequent Injury Trust Fund provides reimbursements and information to employers, insurers, and their agents in those Workers' Compensation claims involving individuals with a pre-existing, permanent impairment.

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PART 1 – GENERAL INFORMATION

HISTORY

The Georgia Subsequent Injury Trust Fund promotes the employment and retention of workers with disabilities. The fund accomplishes this goal by providing protection for employers from excess workers' compensation liability should an employee with a disability sustain an on-the-job injury resulting from or merging with the pre-existing impairment.

The fund began operation on July 1, 1977, when the Georgia Legislature amended the Workers' Compensation Law to create the new agency. Established as a state agency independent of any other department, the fund is governed by a five-member board of trustees appointed for six-year terms by the Governor. Board members include representatives of management, labor, the insurance industry, rehabilitation professionals, and the public at large. Additionally, ex-officio or advisory members include the executive director of the State Board of Workers' Compensation and the Georgia Insurance Commissioner. The board of trustees appoints an administrator who is responsible for the daily management and operation of the fund.

Q The fund is a "second" injury fund. What does that mean?

A second injury fund is a state-mandated monetary reserve designed to remove financial disincentives from employment of individuals with disabilities. Without a second injury fund, the employer or insurer would be forced to bear full indemnity and/or medical and rehabilitation costs if a worker suffered increased disability from a work-related injury because of a pre-existing condition.

Q How does the fund remove financial disincentives from employing individuals with disabilities?

The fund reimburses indemnity and medical costs to employer/insurers on accepted, qualified second injury cases. The reimbursements are subject to deductibles.

FUNDING

Q Is there a membership fee to qualify for recovery from the Subsequent Injury Trust Fund?

No. Any insurance company licensed in Georgia to issue workers' compensation policies or self-insured employer authorized by the State Board of Workers' Compensation is eligible to file a claim for potential reimbursement from the fund.

Q How is the SITF funded?

The fund is *not* funded by taxpayers' contributions. It is funded through assessments against all self-insured employers and workers' compensation insurance carriers in Georgia.

Q How are assessments calculated?

Assessments are calculated on an annual basis in the following manner:

Preceding calendar year's fund disbursements multiplied by 175% minus the fund's net assets as of December 31 of the same calendar year.

NOTE: Each self-insured employer or insurer's contribution varies from year to year depending on the employer/insurer's total Georgia claims payments as well as fund disbursements made during the applicable assessment year.

Q Are assessments levied against all self-insured employers and insurers, regardless of whether they have accessed the fund's resources in the prior calendar year(s)?

Yes. Assessments are levied against all State-authorized self-insured employers and insurers.

Q What is the assessment process?

Between January 1 and 31 of each year, the fund mails to each self-insured employer and insurer a questionnaire asking for the total amount of indemnity, medical, and rehabilitation benefits paid in Georgia during the preceding calendar year.

Q Must insurance carriers and group self-insurers include policyholders' deductibles and self-insured retentions as claims losses in their reports?

Yes; however, fund and third party workers' compensation recoveries received in the applicable calendar year need not be reported as claims losses.

Q *When must this questionnaire be completed and returned?*

The questionnaire must be completed no later than March 1st of the same calendar year.

Q *Does the employer/insurer submit payment with the questionnaire?*

No. The administrator of the fund bills the employer/insurer at a later date, usually on or about July 1st.

Q *What happens if the self-insured employer or insurer does not return the questionnaire on time?*

The employer or insurer will be levied an automatic penalty of $50 per day for each day the report is delinquent or 10 percent of the assessment - whichever is greater.

NOTE: The law does not give the administrator the authority to waive the late reporting penalty regardless of the circumstances under which it was incurred.

THE FUND AND THE ADA

Q *How does the Americans with Disabilities Act (ADA) relate to the Subsequent Injury Trust Fund?*

Title I of the Americans with Disabilities Act forbids discrimination against individuals with disabilities. All employers with 15 or more employees are subject to the ADA.

Under ADA
Employers are prohibited from raising questions during the employment interview or on pre-employment applications regarding a candidate's medical condition or disability.
An employee already employed may not be discharged because of a disability; this requires employers to make reasonable accommodations and to return an employee to work.

Under the Fund
An employer, regardless of whether it is subject to the ADA, is protected from excess liability for disability and medical expenses through reimbursement from the fund when:
The worker with a disability is injured on the job because of the pre-existing impairment; *or*
The pre-existing impairment, combined with the effects of the subsequent injury, causes the employer/insurer to incur greater weekly income benefit and medical costs.
The fund serves as an incentive to those employers who are not subject to Americans with Disabilities Act to provide employment opportunities to persons with disabilities.

Should the fund have accepted a claim for reimbursement, and the employer returned the injured employee to work, the same employer does not face new

deductibles should the employee have a new accident as defined by workers' compensation laws.

Q *If an employer with 15 or more workers cannot ask an employee about the presence of a disability before hiring, how can the employer satisfy the fund's prior knowledge requirement?*

The requirement does not state that knowledge must be obtained prior to the date of employment, but prior to the occurrence of the subsequent injury.

Q *When can an employer who is governed by the ADA ask a potential employee about the presence of a disability?*

An employer may make medical inquiries and may require a medical examination only after a conditional offer of employment has been made.

Q *Medical records and the results of examinations are confidential materials; may an employer release this information to the fund?*

Yes. The Equal Opportunity Employment Commission Technical Assistance Manual contains a section stating that an employer may disclose confidential medical information to workers' compensation boards and commissions and to second injury funds.

PART 2 - ACCESSING THE SUBSEQUENT INJURY TRUST FUND

ELIGIBILITY

Q Who can access the fund?

All licensed workers' compensation insurance carriers and self-insured employers authorized by the State Board of Workers' Compensation in the State of Georgia may access the fund.

Q Under what conditions may an insurance carrier or self-insured employer access the fund?

Four prerequisites must be met for the insurer or self-insured employer's claim to be considered for reimbursement. They are listed here and further explained below:

1. The employee must have a pre-existing permanent impairment.
2. The employer must have knowledge of the prior impairment *before* a subsequent injury occurs.
3. A compensable, on-the-job injury must occur.
4. Additional injury must have occurred, either caused by the prior impairment, or by a combination of the prior impairment and the effects of the subsequent on-the-job injury or accident, thus creating greater employer liability for lost time, medical, and rehabilitation expenses. This is known as merger.

Q Is an employer who is not an authorized self-insurer and who has no workers' compensation insurance coverage eligible to file for potential recovery from the fund?

No. Only self-insurers authorized by the State Board of Workers' Compensation and group self-insurers authorized by the Georgia Department of Insurance are eligible to recover from the fund.

Q Is a qualifying prior impairment restricted to industrial or workers' compensation injuries?

No. Any pre-existing, permanent condition qualifies. The condition may be derived from an automobile accident, personal injury, or an acquired or congenital disease.

PRE-EXISTING, PERMANENT IMPAIRMENT

Q *What qualifies impairment as pre-existing and permanent?*

The law defines permanent impairment as any permanent condition due to previous injury, disease or disorder, which is or is likely to be:

A hindrance or obstacle to employment, or

Should the employee become unemployed, a hindrance or obstacle to re-employment.

EMPLOYER'S PRIOR KNOWLEDGE

Q *What criteria establish prior knowledge?*

The employer must:

1. Have knowledge of the employee's pre-existing condition prior to the occurrence of the subsequent injury.
2. Have reached an informed conclusion that the pre-existing impairment was permanent and likely to be a hindrance to employment or re-employment.

Q *Are any conditions presumptively considered to be permanent and a hindrance to employment?*

Yes. The employer need only establish prior knowledge for any of the following (23) conditions:

1. Epilepsy
2. Diabetes
3. Arthritis (which is an obstacle or hindrance to employment or reemployment)
4. Amputated foot, leg, arm or hand
5. Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than 75 percent bilaterally
6. Residual disability from poliomyelitis
7. Cerebral palsy
8. Multiple sclerosis
9. Parkinson's disease
10. Cardiovascular disorders
11. Tuberculosis
12. Mental retardation provided the employee's intelligence quotient (IQ) is such that he or she falls within the lowest two percent of the general population; provided, however, that it shall not be necessary for the employer to know the employee's actual IQ or actual relative ranking in relation to the IQ of the general population.

13. Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months.
14. Hemophilia
15. Sickle cell anemia
16. Chronic osteomyelitis
17. Ankylosis of major weight bearing joints
18. Hyperinsulism
19. Muscular dystrophy
20. Total occupational loss of hearing, as defined in Code Section 34-9-264
21. Compressed air sequelae
22. Ruptured intervertebral disc
23. Any permanent condition which, prior to the occurrence of the subsequent injury, constitutes a 20 percent impairment of a foot, leg, hand, or arm, or the body as a whole.

Q *Will the employer's prior knowledge requirement be waived if it can be established after the subsequent injury that the employee actually has or had any one or more of the listed (23) presumptive conditions?*

No. The employer must have had actual knowledge of one (or more) of the presumptive conditions *prior* to the occurrence of the subsequent injury.

Q *How does an employer prove prior knowledge when filing a claim?*

The employer must submit a notarized Knowledge Affidavit (Form S.I. "H") outlining the employer's knowledge of the prior permanent impairment and its consideration of permanency and hindrance to employment.

Q *How does an employer get this form?*

The Employer's Knowledge Affidavit form can be downloaded from the fund's Website www.sitf.georgia.gov

Q *Who completes the Employer's Knowledge Affidavit?*

The fund urges the *employer* to fill out this form. The employer should not allow the carrier or its agents to influence completion of the form.

In some instances, insurers or their agents are sending prepared affidavits to employers asking them to sign the affidavits. This practice is ***strongly discouraged*** and could result in investigation of the employer knowledge aspect and cause delay in claim determination.

Q *When can the fund conduct an investigation of the employer's prior knowledge claim?*

If the fund has any questions regarding the validity of the information contained in the Knowledge Affidavit, the fund will conduct its own investigation.

Q *Does submission of the affidavit alone guarantee reimbursement?*

No. Although submission is one of the prerequisites, it does not automatically entitle the employer/insurer to reimbursement.

Q *Can information other than that shown on the affidavit be used to substantiate prior knowledge?*

Yes. If employer records verify prior knowledge, they should be referred to on, and attached to, the affidavit. The employer must certify on its own letterhead that the records attached to the affidavit were contained in the employer's own files *prior to* the employee's subsequent injury date.

Q *What are some of the types of records that may be used to help establish prior knowledge?*

Some examples are:

1. Post-employment offer physical/health history questionnaire
2. Physical examination reports
3. Group insurance records
4. Personnel actions
5. Sick leave records
6. Job modification records
7. Prior workers' compensation claims

Q *How does the employer know the affidavit is acceptable to the fund?*

The employer should make certain the affidavit addresses the following questions:

1. Does the statement of knowledge make sense?
2. Is the statement supported by facts?
3. Are the facts properly outlined?
4. Have these facts been relayed to the fund?
5. Did an authorized, active notary public notarize the affidavit?

Q *Who should sign the affidavit?*

An individual who has the authorization to make personnel decisions or has significant input in recommending personnel actions should sign the affidavit. The fund will judge the signatory's acceptability based on that measure.

Q *Must an employer gain knowledge of the employee's pre- existing permanent condition before or at the time of hire?*

No. The employer need only obtain the requisite knowledge prior to the occurrence of the subsequent injury. This knowledge can be obtained at any time after a conditional offer of employment has been made.

Q *If the employer can establish prior knowledge of a presumptive condition and the employee has a compensable subsequent injury, does the case automatically qualify for reimbursement?*

No. The employer must still prove merger between the pre-existing condition (of which the employer had knowledge) and the subsequent injury.

Q *Must an employer file the Employer's Knowledge Affidavit or pre-register knowledge of a permanent condition with the fund prior to the occurrence of a subsequent injury?*

No. The Employer's Knowledge Affidavit is submitted *after* the occurrence of the subsequent injury and at the time the employer/insurer files or activates its claim against the fund.

Q *Is potential fund recovery restricted to the 23 conditions referred to as "presumptive" conditions in Section 34-9-361 of the Official Code of Georgia Annotated?*

No. Any other pre-existing, permanent impairment may qualify as long as the employer can show:

1. Knowledge of that condition prior to the occurrence of the subsequent injury.
2. Consideration that such prior impairment was permanent and likely a hindrance to employment.

COMPENSABLE, ON-THE-JOB INJURY

Q *What is a compensable, on-the-job injury?*

A compensable, on-the-job injury is defined by Georgia Workers' Compensation Laws.

MERGER

Q *What is a merger?*

Merger occurs when:

1. An injury arises from a pre-existing impairment; *or*
2. The resulting employer liability for disability following the subsequent injury is greater than it would have been had the pre-existing impairment not been present; *or*
3. Death would not have been accelerated had the pre-existing impairment not been present.

Q *How does the employer know a merger has occurred?*

Merger occurs when certain conditions are met:

1. The subsequent injury would not have occurred had the pre-existing impairment not been present. (**Example:** An employee with epilepsy experiences a seizure and falls off a loading dock, breaking a leg and suffering a serious concussion.) OR

2. 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, *and, the employer has been required to pay and has paid compensation for the greater disability.* (**Example:** The employee's return to work possibility from the subsequent injury has been substantially prolonged, or is non-existent, because the pre-existing condition severely impacted the employee's recuperation time from the subsequent injury. In addition, the employer may also have to either find alternative employment for the injured worker, or bear costs for retraining and job placement assistance.) OR

3. Death would not have been accelerated had the pre-existing, permanent impairment not been present. (**Example:** An employee with prior cardiovascular disease dies after sustaining a compensable heart attack.)

Q *How does the employer/insurer prove that a merger has occurred?*

Merger must be supported by evidence. The employer must present either medical evidence or factual evidence to support merger. Conjecture on the part of the employer that the prior impairment caused the subsequent injury to occur, or in conjunction with the subsequent injury to create greater disability, is not acceptable proof of merger.

Usually, medical evidence will either support or disprove merger; but the medical profession cannot determine the employer's obligation to pay for the greater disability.

Q *How is merger proven in cases where death has been accelerated because of a pre-existing, permanent impairment?*

In the majority of death cases, merger is generally proven or disproved by medical evidence.

Q *What information should an employer/insurer submit to the fund to aid in the fund's evaluation of merger?*

The employer/insurer should forward as much medical information as possible about the prior impairment and the subsequent injury. *The burden to produce this information falls solely on the employer/insurer.*

Q *What are the elements of an official statement of merger?*

An official merger statement should be dated and signed by the injured employee's treating physician and should be on the doctor's letterhead. Direct questions about merger should be submitted to the physician, and he/she should be allowed to review medical evidence and draw his/her own conclusion.

Q *Should an employer/insurer send a pre-prepared merger statement to the injured employee's treating physician?*

Submitting pre-prepared merger statements is *strongly discouraged.* In many instances they are of little value to assess statutory merger and will likely necessitate additional investigation.

Q *May the fund question the validity of the statement of merger?*

Yes. If merger is questionable or requires clarification, the fund may conduct its own investigation into the merger issue.

Q *If the employer must establish excess liability because of the pre-existing condition, can the employer actively pursue its claim before the excess liability has been incurred?*

Yes. But in some cases merger cannot be established in the initial stages. If factual information supporting merger does not develop until late in the case, the decision to reimburse may be delayed. The employer/insurer, however, may file an inactive claim and activate it when merger and greater financial liability can be proven.

PART 3 - FILING OF CLAIMS

DOCUMENTATION

Q What documents must be submitted to file a claim with the fund?

The following documents must be submitted:

First: Notice of Claim (Form S.I. "A").

Then:

1. Employer Knowledge Affidavit (Form S.I. "H") plus supporting documentation. Documentation supporting merger between the pre-existing condition and subsequent injury.
2. Copies of any forms generated and forwarded to the State Board of Workers' Compensation, any awards, orders, etc.
3. Other relative documentation as deemed necessary to assess the claim and determine the fund's reimbursement liability.

Q How does the employer/insurer get the forms necessary for filing a claim?

The forms can be downloaded from the agency's Website - www.sitf.georgia.gov

Q Can the fund request additional information not included in the forms?

Yes. The fund periodically reviews each claim and may request additional information if necessary.

Q Can multiple accident dates be included on one form?

No. Each accident date should be filed using a separate Notice of Claim.

Q Does the fund supply a health history questionnaire for an employer's use to document an employee's pre-existing condition?

No. However, the employer should communicate with its workers' compensation carrier or legal advisor before having the employee complete a health history questionnaire.

PROCESS

Q What is the first step involved in filing a claim with the fund?

The employer/insurer must notify the administrator of the fund *in writing* of any possible claim against the fund.

Q When should this information be submitted to the administrator?

The administrator must be notified as soon as practicable, but in no event later than 78 calendar-weeks following the injury OR, payment of an amount equivalent to 78 weeks of income or death benefits, whichever occurs last.

But in either case, prior to final settlement of the employee's claim.

Q How should the information be submitted to the administrator?

Information must be submitted in accordance with the SITF's Rules and Regulations, on the Notice of Claim - Form S.I. "A" (See Appendix B – Rule 622-1-.04(1).

Q To what address should the claim be submitted?

Claims may be submitted either of three ways:
Website – www.sitf.georgia.gov
FAX - (404) 206-6363; or mailed to:
Georgia Subsequent Injury Trust Fund, Suite 500 North Tower, 1720 Peachtree Street, NW, Atlanta, Georgia 30309-2462

Q May the claim be submitted to the State Board of Workers' Compensation?

No. The claim must be submitted directly to the Subsequent Injury Trust Fund.

If the Notice of Claim is not filed with the fund, it may cause the claim to be barred by the statute of limitations if the claim does not reach the fund within the time frame of the statutory filing requirement.

Q What happens if the notification is not submitted to the administrator before 78 calendar weeks, or 78 weeks of equivalent payment of benefits, or prior to settlement of the employee's claim?

The employer/insurer is barred from possible entitlement for reimbursement.

Q *Is there an optimum time for filing a claim?*

In addition to observing the statutory time frame for filing claims, it is helpful for the employer/insurer to consider key points in a case to assist in deciding when to file, such as:

1. When it is recognized that there is some form of pre-existing condition.
2. When the insurer is establishing reserves that approach or exceed the deductibles.
3. If a lump sum payment equivalent to or more than 78 weeks of income benefits is anticipated AND more than 78 calendar weeks have elapsed from the date of accident.
4. If a lump sum settlement is contemplated.

Q *When is filing of the claim acknowledged?*

The fund will acknowledge all claims within two weeks of receipt. Employer/insurers who do not receive an acknowledgment within two weeks should call the fund to confirm receipt of the Notice of Claim.

Q *After the fund has been notified of a potential claim, can the fund make a determination whether an employer/insurer's claim qualifies for reimbursement if the compensability of the employee's claim (carrying the accident date for which fund reimbursement application is made) is in question?*

No. A prerequisite for a potential reimbursement is that the employee must have sustained a compensable accident and that the employer's liability was established in accordance with Georgia Workers' Compensation Laws.

Q *Can the fund make a decision on a new claim where only the first report of injury, the Notice of Claim, and the Employer's Knowledge Affidavit was submitted?*

No. The fund must also have:

1. Medical documentation of the prior and subsequent injuries and, where indicated, investigative reports supporting compensability.
2. The statement of merger.

Q *Can the fund's receipt of an Employer's Knowledge Affidavit, medical narratives, or State Board of Workers' Compensation forms, classify a claim as having been filed within the statutory time frame?*

No. The statute is very specific in stating that the administrator must be notified of a potential claim. (See Appendix B – Rule 622-1-.04(1).

INACTIVE CLAIM FILING

The fund generally applies two statuses for claim filing -- inactive and active.

Q *What are inactive claims?*

Inactive claims are filed against the fund to toll the statute only. Essentially, this gives the employer/insurer the right to pursue the claim at a later date without running the risk of the statutory filing requirement expiring.

Q *How does the employer/insurer indicate it is filing under inactive status?*

The employer/insurer should check the appropriate box on the Notice of Claim (Form S.I. "A").

Q *When should an employer/insurer file an inactive claim?*

When:

1. The employee's claim is in litigation or has been controverted; however, the fund must be kept advised while the employer/insurer defends the claim. (See Rule 622-1-.08.)
2. The employee's claim is not anticipated to exceed the fund's deductibles for indemnity and medical expenses.
3. The employer/insurer is not certain, subject to its further investigation, whether it can prove a pre-existing permanent impairment, employer's prior knowledge, or merger.

Q *Must any other documentation be attached to the Notice of Claim when filing under inactive status?*

No. Attachments such as medical reports, affidavits and merger statements are not necessary until the claim is activated.

Q *What happens to a claim filed under inactive status?*

The claim is placed on a diary with automatic closure after one year if there has been no request from the employer/insurer to activate the claim.

Q *Can the inactive claim be reactivated after it is closed?*

Yes. The employer/insurer may request the file to be reopened at a later date should a change in circumstances warrant active pursuit.

Q *If an employer/insurer files "to toll the statute only," and the file ultimately closes because of inactivity, does the employer/insurer have the right to reopen the file?*

Yes. The employer/insurer should forward a letter to the fund stating a desire to actively pursue the claim, and the fund will forward the instructions for submission of necessary documents.

ACTIVE CLAIM FILING

Q *What are active claims?*

Active claims are those that are going to be pursued by the employer/insurer immediately.

Q *When should an employer/insurer file an active claim?*

When:

1. The employee's claim is not in litigation or has not been controverted.
2. The employee's claim is anticipated to exceed the fund's deductibles for indemnity and medical expenses.
3. The employer/insurer feels it can prove knowledge of a prior, permanent impairment, and merger.

Q *Can any other documentation be forwarded in addition to the Notice of Claim when filing under active status?*

Yes. The employer/insurer may also submit:

1. Employer's Prior Knowledge Affidavit and available documentation from employer's files.
2. Documentation supporting merger (including medical narratives, rehabilitation reports, diagnostic test results, etc. for both the prior **and** subsequent conditions).
3. Copies of any forms generated and forwarded to the State Board of Workers' Compensation (awards, orders, etc.).

Q *Should these documents be mailed separately or together?*

Except for the initial filing of the Notice of Claim (to prevent the statute of limitations from running), the fund strongly recommends the requested forms and supporting documents be submitted in one mailing. This courtesy will expedite the evaluation process.

Q *What happens to a claim filed under active status?*

A claims specialist is assigned to the case and forwards a questionnaire to the claiming party to obtain any additional information not previously received with the Notice of Claim.

Q *Is there any other information that should be submitted to the fund in addition to the documentation previously mentioned?*

Yes. The fund should also be notified if settlement negotiations between the employer/insurer and the employee begin, along with the settlement amount under consideration.

If an employer/insurer withdraws a claim, may it be filed again in the future?
Yes. But a withdrawn claim that is reactivated is handled as a new claim, and therefore is still subject to the statutory filing requirement.

CLAIMS EVALUATION PROCESSING TIME

Q *What is the typical amount of time involved in processing an active claim?*

Generally, the fund makes every attempt to complete its evaluation in less than 90 days from receipt of the Notice of Claim or the reactivation of a previously closed or inactive case.

Q *Are there ever exceptions to the 90-day guideline?*

Yes. Exceptions include, but are not limited to:

1. Complex cases requiring extensive investigations, legal and/or medical advisory input.
2. Non-cooperation of parties contacted during the course of the fund's investigation.
3. Cases in which the employer/insurer has failed to provide the proper documentation in a timely fashion.

PART 4 - REIMBURSEMENT

The fund operates in a reimbursement capacity only. It is the responsibility of the employer/insurer to pay all medical expenses and indemnity benefits up front, and then apply for reimbursement from the fund.

BEFORE FINAL ACCEPTANCE

Q If a claim is accepted by the fund, what is the process of gaining final approval of the claim?

1. The fund generates a formal reimbursement agreement.
2. The fund forwards agreement to employer/insurer.
3. Employer/insurer signs and returns reimbursement agreement.
4. The fund forwards reimbursement agreement to the State Board of Workers' Compensation for final approval. The Board-approved reimbursement agreement is returned to SITF.
5. SITF forwards the employer/insurer a copy of the approved reimbursement agreement.
6. Employer/insurer submits a Reimbursement Request (Form S.I."C") to the fund. The form contains detailed instructions on its reverse side explaining how to itemize indemnity and medical expenses and to present proof of payment. Further, Rule 622-1-.06 provides for alternate time and paper-saving reimbursement request processing procedures.

Q Who should sign the reimbursement agreement?

An individual with the employer/insurer who either has authority to adjust reserves and/or is in an executive position.

AFTER FINAL ACCEPTANCE

Q What must the insurer do when the reimbursement agreement is received?

The insurer must:
First: - Reduce reserves to the indemnity and medical (includes rehabilitation costs) deductibles.

Then:
Submit the Reimbursement Request with proof of payment to the fund. This form contains language where the insurer, via signature, certifies that the reserves have been reduced to the deductible levels and where the insurer and self-insured employer certify that investigation has been performed to ensure an employee's continued entitlement to compensation.

Q What should the self-insured employer do when the reimbursement agreement is received?

Self-insured employers should:
First: - Submit the Reimbursement Request with proof of payment to the fund.

NOTE: The reserve reduction requirement does not apply to self-insured employers.

Then: - Investigate to ensure the employee continues to be entitled to compensation.

Q What should the insured employer do when it is notified of fund acceptance?

Insured employers should - contact the workers' compensation insurance carrier or agent for the applicable date of accident and inquire whether the (insured) employer may be entitled to a premium refund due to experience modification resulting from fund acceptance and later reimbursements.

Q To whom should the Reimbursement Request be submitted?

It should be submitted to the fund.

DEDUCTIBLES

Q *What are the deductibles of indemnity benefits paid by employer/insurers before the fund reimburses?*

The employer/insurer pays all compensation provided by workers' compensation laws and fund reimburses employers/insurers all weekly income benefits after 104 weeks of payment.

Q *What types of payment qualify for inclusion in the 104- week payment schedule?*

The 104 weeks may be comprised of a combination of any of the following:

1. Temporary total benefits.
2. Salary paid in lieu of weekly income benefits.
3. Temporary partial benefits.
4. Permanent partial benefits.
5. State Board of Workers' Compensation approved advance payments.
6. Lump-sum settlements (divided by the temporary total benefit rate).

Q *What are the deductibles for reimbursement of medical benefits paid by employers/insurers?*

If an employer/insurer has paid medical expenses on behalf of the employee, the fund will reimburse as follows:

1. Fifty percent (50%) reimbursement of all medical expenses paid which exceed $5,000 but do not exceed $10,000.
2. One hundred percent (100%) reimbursement of all medical expenses paid which exceed $10,000.

Q *Are rehabilitation costs reimbursed as medical expenses?*

Yes.

Q *Does the fund pay medical and rehabilitation expenses directly to the service providers?*

No. It is the responsibility of the employer or insurer to make payments in accordance with Georgia Workers' Compensation Laws, its Rules and Regulations and Fee Schedules. The fund reimburses; it does not pay up front.

Q *Does the fund pay indemnity benefits directly to the employee?*

No. The employer or insurer must pay the indemnity benefits and be reimbursed by the fund.

Q *If a case has been accepted for reimbursement, must the employer/insurer wait until both the indemnity and medical deductibles have been exceeded before requesting reimbursement?*

No. In many instances, the medical/rehabilitation costs have exceeded its applicable threshold (deductible) before 104 weeks of indemnity benefits were paid to the claimant. Reimbursement of rehabilitation and medical costs may be requested as soon as they exceed $5,000.

GENERATION OF PAYMENT

Q *When are reimbursement payments made to the employer or insurer?*

Requests for reimbursement are audited on a first-come, first-served basis; reimbursement checks are generally processed bi-weekly.

APPORTIONMENT/DENIAL OF MEDICAL EXPENSES

Q *Can the employer or insurer be denied reimbursement for medical expenses it paid?*

Yes. Section 34-9-364 of the Official Code of Georgia gives the administrator the authority to apportion or deny reimbursement of certain medical expenses the employer/insurer has paid.

Q *Under what circumstances can such medical expense reimbursement be denied?*

Reimbursement can be apportioned or denied provided there are clear and unequivocal facts to establish that the subsequent injury to the permanently impaired employee was not caused by, or was in any way related to, the employee's pre-existing impairment.

CLAIMS MANAGEMENT RESPONSIBILITY

Q *Is it the fund's responsibility to handle the employee's claim once the employer/insurer has submitted documentation to file a claim, or when the fund has accepted the claim for reimbursement?*

No. The employer/insurer must maintain responsibility to handle the employee's claim throughout the life of the claim.

Q *What happens if the employer or insurer fails to meet this responsibility after the claim has been accepted for reimbursement?*

Reimbursement to the employer or insurer may be suspended.

The fund has neither the mandate nor the staffing to manage the employee's claim. However, the employer or insurer must keep the fund informed of any case developments as they occur.

PART 5 - SETTLEMENTS AND RETURNING AN INJURED WORKER TO WORK

SETTLEMENT PRIOR TO FUND CLAIM ACCEPTANCE

Q What happens if the employer/insurer and the employee settle the employee's claim prior to the fund's acceptance of the employer/insurer's claim?

In such a case, the fund takes the position that it is not party to the settlement and therefore not bound by the terms of the settlement. The fund may later question the reasonableness of the settlement amount.

Q Does this mean the fund closes the case?

No. The fund continues to review the pending claim and settlement but will reserve the right to defend reimbursement on all Title 34 issues, if necessary.

SETTLEMENT FOLLOWING FUND CLAIM ACCEPTANCE

Q What happens if the employer/insurer and the employee settle a claim after the fund and the employer/insurer reach a reimbursement agreement?

The employer/insurer must obtain the approval of the administrator of the fund prior to reaching a settlement agreement with the employee.

Q What happens if the employer/insurer fails to get the fund's approval for a claims settlement with the employee, and the claimant's settlement is approved by the State Board of Workers' Compensation?

The reimbursement agreement between the employer/insurer and the fund will become null and void. Upon the request of the administrator of the fund, the State Board of Workers' Compensation shall rescind the reimbursement agreement.

Q How does the employer/insurer go about gaining the administrator's approval?

The employer/insurer must submit a settlement authority request in writing to the fund. The fund will review the request, its claim file, and may request other pertinent documentation; then the fund will render a decision regarding the acceptability of the settlement. The fund acknowledges all settlement authority requests. If a settlement mediation conference is imminent, the fund must have complete information **at least 21 days** prior to the mediation date. This courtesy will allow the fund to make an informed assessment of the settlement request.

Q *Does the fund negotiate an employee's settlement with the claimant's attorney?*

No. Except in isolated instances, the fund grants settlement authority to the employer/insurer and its representative negotiates with the claimant or the claimant's attorney.

RETURNING AN INJURED WORKER TO THE WORKPLACE

Q *What does the "no new deductibles" provision mean?*

After the fund has accepted an employer/insurer's claim for reimbursement and the employee returns to work with the same employer without a break in service, the employer/insurer does not have to satisfy new indemnity and/or medical deductibles if the employee sustains a new, compensable injury.

Q *Does this provision apply even if the employer has changed insurance carriers between the time of the accident date that resulted in the initial fund claim acceptance and the new accident date for which a claim could be made against the fund?*

Yes. The employer or insurer on the risk for the new subsequent injury will receive credit for indemnity and medical deductibles previously met.

Q *What are the conditions of the no new deductibles provision?*

To qualify for the no new deductibles provision, several conditions must be met:

1. Employee must return to work for the *same employer*.
2. Employee must return to work *without a break in service*.
3. New injury (ies) must merge with the same prior impairment that resulted in the fund's acceptance of the prior claim(s).

Q *Must the employer/insurer submit another Notice of Claim, Knowledge Affidavit, and Proof of Merger for the new subsequent injury?*

Yes. However, most of the data collected on the previously accepted claim will serve as the basis for the new claim.

PART 6 - DENIAL AND APPEAL

DENIED CLAIMS

Q What happens if the fund determines that an employer/ insurer's claim does not qualify for reimbursement?

The fund will issue a letter of denial to the self-insured employer, the insurance carrier, or the authorized servicing agent.

Q What are the employer/insurer's options when a claim has been denied?

When a claim has been denied:
The employer/insurer *must* request a hearing with the State Board of Workers' Compensation within 90 days of receipt of the letter of denial.
The employer/insurer may request reconsideration of the denial.

Q How is reconsideration requested?

The employer/insurer may submit additional information that was impossible for the employer to obtain prior to the fund's denial no later than 15 calendar days before the initially scheduled hearing date.

A request for reconsideration or submission of additional claim information does not extend the 90-day period during which the employer/insurer must file for a hearing to challenge the fund's denial.

STATE BOARD OF WORKERS' COMPENSATION HEARINGS

Q How does the employer/insurer request a hearing to challenge a denied claim?

Within 90 days from the time of receipt of the fund's letter of denial, the employer/insurer may challenge the fund's denial by submitting Form WC-14 - Notice of Claim/Request for Hearing to the State Board of Workers' Compensation.

The Form WC-14 must also be copied to the fund. A dispute may, upon request of either party, be referred to the Alternate Dispute Resolution Unit of the State Board of Workers' Compensation.

Q What happens if the employer/insurer fails to file a Request for a Hearing within 90 days from receipt of the denial letter?

The employer/insurer will be barred, by statute, to challenge the fund's denial.

Q Should a hearing against the fund be requested while the compensability of an employee's claim is unresolved?

No. The issue of compensability should be resolved before a hearing is requested to determine the fund's reimbursement liability.

APPENDIX A - FLOW CHART OF CLAIMS FILING PROCEDURES

1. Employee hired

2. Employer establishes knowledge of permanent, pre-existing impairment

3. Employee is injured on the job
(Direct result of permanent, pre-existing impairment *or* subsequent injury and prior impairment combine to cause greater employer liability for disability *or* death is accelerated because of prior impairment.)

4. Employer/Insurer files Notice of Claim (Form S.I. "A") with administrator of the fund (within 78 calendar weeks *or* before payment equivalent to 78 calendar weeks of income or death benefits *but in either case* prior to settlement of the employee's claim.)

5. Upon acknowledgment from the fund, employer submits to the fund:
   - Employer Knowledge Affidavit (Form S.I. "H").
   - Documentation supporting merger (Prior and subsequent injury medical narratives, operative reports, etc.).
   - Copies of forms sent to State Board of Workers' Compensation, awards, orders, etc

6. Employer/Insurer receives notice of either acceptance or denial

Accepted Claims

Sign/return Reimbursement Agreement.

The fund forwards to State Board of Workers' Compensation.

The fund mails Board approved Reimbursement Agreement to the Employer/Insurer.

Employer/Insurer files Reimbursement Request (Form S.I. "C").

<u>Denied Claims</u>

Employer/Insurer submits Form WC-14 Notice of Claim/Request for Hearing to State Board of Workers' Compensation.

Employer/Insurer requests reconsideration of the fund no later than 15 calendar days before the initially scheduled hearing date.

APPENDIX B - RULES AND REGULATIONS OF THE SUBSEQUENT INJURY TRUST FUND

RULE 622-1-.01 BOARD OF TRUSTEES

The organization of the Board of Trustees of the Subsequent Injury Trust Fund shall be as follows:

Meetings are to be held at least quarterly.

Special meetings can be held, with reasonable written notice, to board members by the Chairman or any two voting members.

Three voting members must be present to constitute a quorum for conducting business.

Time, place, names of those present, all official action of the Board, and when requested, a member's approval or dissent with reason shall be recorded in the minutes.

The administrator shall cause the minutes to be transcribed and presented for approval or amendments at the next regular meeting.

Minutes, or a true copy, shall be open for inspection during regular office hours.

RULE 622-1-.02 COST OF ADMINISTRATION; BUDGET.

The operating budget of the Subsequent Injury Trust Fund shall be computed on a fiscal year basis, and the Subsequent Injury Trust Fund's fiscal year shall be the same as the fiscal year for the State of Georgia.

The administrator shall submit to the Board of Trustees a proposed budget covering the cost of administration of the fund for each fiscal year. This budget should be submitted no later than the third quarter of the fiscal year preceding the fiscal year in the proposed budget. The budget shall be reviewed by the Board of Trustees at the quarterly board meeting corresponding with the third quarter and submitted to the Office of Planning and Budget for comment. The Office of Planning and Budget should return this budget proposal to the Board of Trustees within a reasonable time to enable implementation of the budget by the Board of Trustees.

RULE 622-1-.03 (1) PAYMENT OF NON-DEPENDENCY BENEFITS INTO THE SUBSEQUENT INJURY TRUST FUND.

For accident dates prior to July 1, 1995, the employers' payments to the Subsequent Injury Trust Fund in no-dependency death cases will be initiated through the use of a Subsequent Injury Trust Fund Form "F" referred to as a "No Dependency Agreement." This agreement must be submitted to the State Board of Workers' Compensation for approval and, upon approval, the employer will process the payment in accordance with Code Section 34-9-358.

RULE 622-1-.03(2) PAYMENT OF ASSESSMENTS TO FUND BY INSURERS AND SELF-INSURERS.

Each insurer and self-insurer shall make payments to the fund in an amount equal to that proportion of 175 percent of the total disbursement made from the fund during the preceding calendar year less the amount of the net assets in the fund as of December 31 of the preceding calendar year which the total workers' compensation claims paid by the insurer and self-insurer bears to the total workers' compensation claims paid by all insurers and self-insurers during the preceding calendar year. The administrator is authorized to reduce or suspend assessments for the fund when a completed actuarial survey shows that further assessments are not needed. Adjustments relative to any prior years' assessment will be added to or credited against each insurer's or self-insurer's most recent calendar year's assessment when total claims losses reported to the fund necessitated revising the prior years' assessment rate. An employer who has ceased to be a self-insurer prior to the end of the calendar year shall be liable to the fund for the assessment of the calendar year and/or the adjusted assessment, if any, of the previous calendar years.

RULE 622-1-.03(3) REPORTS BY EMPLOYERS OF COMPENSATION AND BENEFITS PAID; FAILURE TO PAY ASSESSMENTS

As soon as practicable after January 1 but not later than January 31 of each calendar year, the administrator shall forward to each insurer and self-insured employer a questionnaire asking for the total amount of compensation, medical benefits, and rehabilitation benefits paid by each insurer and self-insured employer during the preceding calendar year. The total amount shall consist of all gross paid losses consisting of indemnity, medical and rehabilitation benefits paid, including those paid through deductibles and self-insured retentions. The insurer or self-insurer may deduct from the gross paid losses those amounts the Subsequent Injury Trust Fund paid during the preceding calendar year, third party (Workers' Compensation) recoveries, and losses under federal compensation laws. Insurers and self-insured employers cannot use paid Workers' Compensation Board and Subsequent Injury Trust Fund assessments to reduce gross claims payments reported. This report is to be completed and returned to the administrator no later than March 1 of the same calendar year in which the request for this information is submitted. Failure to submit the report to the administrator carrying a post mark date on or prior to March 1 shall result in an automatic penalty of $50.00 per day for each day the report is delinquent or 10 percent of the assessment, whichever is greater. This penalty will be added to the assessment.

Any assessment levied or established in a specified amount shall constitute a personal debt of every employer or insurer so assessed and shall be due and payable to the Subsequent Injury Trust Fund when the administrator calls for payment. In the event of failure to pay any assessment upon the date determined by the administrator, the administrator may file a complaint for collection against the employer or insurer in a court of competent jurisdiction.

RULE 622-1-.04 FILING CLAIMS AGAINST THE SUBSEQUENT INJURY TRUST FUND.

(1) An employer or insurer shall notify the administrator of the Subsequent Injury Trust Fund of any possible claim against the Fund as soon as practical, but in no event later than Seventy-Eight (78) calendar weeks following the injury or the payment of an amount equivalent to Seventy-Eight (78) weeks of income or death benefits, whichever occurs last. Notification shall be in writing, transmitted on the facsimile machine, or transmitted electronically and shall be effective on the date of receipt of the notice by the Subsequent Injury Trust Fund. The employer or insurer must submit or electronically transmit Subsequent Injury Trust Fund Form "A", referred to as "Notice of Claim." In addition, the employer or insurer must provide the following:

- Employer's knowledge statement pursuant to Rule 622-1-.05 of the Rules and Regulations of the Subsequent Injury Trust Fund;
- Documentation supporting merger between the subsequent injury and prior impairment; and
- Proof of payment of weekly income benefits to the injured employee in excess of 104 weeks and/or payments for medical benefits in excess of $5,000.00.
- The required format to complete the above will be available from the Subsequent Injury Trust Fund or its website.

(2) The Reimbursement Agreement will contain a section for the insurer to certify that reserves have been reduced to the appropriate threshold levels. In addition, the reimbursement request form will contain a section for continued certification that reserves have been lowered to the appropriate threshold levels.

Failure to provide certification as required above, or if evidence indicates failure to reduce reserves, reimbursement from the Subsequent Injury Trust Fund will be suspended.

(3) When the employer returns an individual to work, and that employer has had a reimbursement claim in reference to that employee previously accepted by the fund, the employer need not comply with additional mandatory indemnity or medical deductibles in the event that the employee sustains a new accident that merges with the prior impairment that originally resulted in fund acceptance. Examples of reimbursement are as follows:

If the employee, in a case accepted by the Subsequent Injury Trust Fund for reimbursement, returns to work with the same employer, and the same employer has exhausted both indemnity and medical deductibles, the Subsequent Injury Trust Fund will resume reimbursement without further deductibles applicable to the employer.

In the above example, if the employee returns to work and sustains a new injury, and the employer has exhausted the indemnity deductible but not the medical

deductible, the Subsequent Injury Trust Fund will resume indemnity reimbursements without further indemnity deductibles applicable to the employer, and the employer will exhaust the remaining portion of the medical deductible on the previous accident that resulted in Subsequent Injury Trust Fund acceptance for reimbursement before the Fund will reimburse medical expenses.

If the employee returns to work and sustains a new injury, and the employer has not exhausted the indemnity deductible but has exhausted the medical deductible, the Subsequent Injury Trust Fund will resume reimbursement of medical expenses with no further medical deductibles applicable to the employer. The employer will be required to exhaust the remaining indemnity deductible as a result of the previous claim that required Subsequent Injury Trust Fund reimbursement before the Fund will reimburse indemnity expenses.
Paragraphs (a), (b) and (c) will apply in the event a new insurer has assumed coverage for the employer.

This provision does not apply if the employee returns to work for a new employer or there has been a break in service by the employee and employer.

(4) The fund shall reimburse only those indemnity medical, and rehabilitation expenses that the employer or insurer was legally obligated to pay, and has actually paid to the employee or claimant, including, but not limited to, discounts granted by the service provider. The fund shall reimburse such expenses at a rate not exceeding the usual and customary charges. The fee schedules adopted by the State Board of Workers' Compensation shall be presumed to indicate the usual charges to any given service; except, however, where the employer or insurer was eligible for further cost reductions, the fund will reimburse the lesser amount.

(Rule 622-1-.04(1) and (4) amended July 11, 2000.)

RULE 622-1-.05 EMPLOYER'S KNOWLEDGE STATEMENT.

The employer is required to submit a notarized knowledge affidavit containing information outlined in the following format:

EMPLOYER'S KNOWLEDGE AFFIDAVIT

On _____ (Date of first knowledge), I _____ (Name), the _____ (Title)

for _____ (Employer), learned that _____ (Employee) SSN _____

had _____ (Type of prior impairment). I received this information in the

following manner: _____

_____

I considered it a permanent physical impairment because:_____

_____

In addition, I considered the impairment likely to be a hindrance to employment because:_____

_____

If this affidavit is prepared by someone other than the appropriate employer representative, please identify:

_____
Name

_____

NOTICE TO EMPLOYER:

If this document is pre-prepared and submitted to you for signature, carefully review this document to make sure the Information outlined is consistent with your knowledge of the prior impairment.

I, the undersigned employer representative, hereby provide the above information under oath.

_____
Employer Representative

_____
Title

_____ Telephone No.:_____
Notary Public

Expiration date:_____ Date:_____

IF YOU HAVE A DISABILITY AND NEED ASSISTANCE IN COMPLETING THIS FORM, PLEASE CONTACT THE SUBSEQUENT INJURY TRUST FUND'S ADA COORDINATOR AT SUITE 500, NORTH TOWER, 1720 PEACHTREE ST. NW, ATLANTA, GA 30309-2462, TELEPHONE NO. (404) 206-6360; FAX NO. (404) 206-6363; TDD NO. (404) 206-5053

WEBSITE: www.ganet.org/sitf/
IMPORTANT : See Reverse Side for Instructions

SI"H", 6/01

INSTRUCTIONS

1. The affiant must be someone who has firsthand knowledge of the worker's pre-existing condition such as an individual in an executive, personnel, or personnel-advisory capacity, or, if an employer is subject to the Americans With Disabilities Act, the designated custodian of (medical) records.
2. Attach any documentation or records that were in the employer's possession prior to the subsequent injury. If you attach documents, these must be accompanied by certification on employer's letterhead that said documents were contained in employer's files.

   Any reports specifically referred to in the affidavit must be attached and certified.
3. The employer should identify the actual date of knowledge of the prior impairment.
4. The employer, if possible, should list any individuals either currently or formerly working for the employer who may have firsthand knowledge of the employee's pre-existing disability.

a.	Name	Address	Telephone No.
b.	Name	Address	Telephone No.
c.	Name	Address	Telephone No.

RULE 622-1-.06 PROCEDURES FOR PAYMENT OF REIMBURSEMENT BENEFITS BY THE FUND.

(1) In order to establish payment for reimbursement benefits from the Subsequent Injury Trust Fund,

(a) an agreement setting forth-factual information establishing the employer's right to reimbursement must be accomplished by the use of Subsequent Injury Trust Fund Form "B", referred to as "Reimbursement Agreement." This Agreement will be initiated by the Subsequent Injury Trust Fund and forwarded to the employer or insurer for signature. The Agreement must be approved by the State Board of Workers' Compensation.

(b) The employer will be required to submit an itemized statement of weekly income benefits paid to the injured employee. In addition, an itemized statement of medical benefits paid on behalf of the claimant must be submitted to the Subsequent Injury Trust Fund, along with providers' charges or a fee schedule audit. An employer or insurer who can provide a certified counterpart of its electronically generated or computer-generated pay document which identifies payment date, provider service, treatment (CPT) codes, and the amount paid may be relieved from the requirement of providing the Subsequent Injury Trust Fund with copies of providers' charges. The Subsequent Injury Trust Fund may require narrative reports when deemed reasonably necessary by the Subsequent Injury Trust Fund. However, where the reimbursement request is based on documented,

future medical and rehabilitation expenses which have been paid by the self-insured employer or insurer in accordance with a settlement agreement which provides that said funds will be set aside in a trust or similar funding mechanism consistent with federal laws and/or regulations; and, that said funds will be used solely for medical and rehabilitation expenses, the Subsequent Injury Trust Fund is authorized to reimburse such funds set aside in accordance with the usual and customary charges of the anticipated medical and rehabilitation expenses.

(c) Weekly income benefits and medical benefits reimbursement requests will be outlined on Subsequent Injury Trust Fund Form "C", referred to as "Reimbursement Request Form." No reimbursement will be made unless a Reimbursement Request form is completed and signed by the claiming party. The employer or his insurer is required to attest to their efforts to assure that the injured employee is entitled to receive, or to continue to receive workers' compensation benefits. Failure to comply with this regulation may subject the claim to a denial of reimbursement benefits. After the initial fund payment, reimbursement requests may be made in 13-week intervals.

(2) In the event the employer and the Fund fail to reach an agreement, the claiming party may make application to the State Board of Workers' Compensation for a hearing in regard to the matters at issue through the use of Form WC-14, Notice of Claim/ Request for Hearing. The Form WC-14 shall be directed to the State Board of Workers' Compensation with a copy forwarded to the Subsequent Injury Trust Fund.

(3) When the Subsequent Injury Trust Fund denies a reimbursement claim submitted by an employer, the employer may move for reconsideration of the denial by submitting to the administrator of the Trust Fund such additional information which was impossible for the employer to obtain prior to the Trust Fund's denial no later than 15 calendar days before the initially-scheduled hearing date. The parties should make every attempt to resolve their differences prior to the hearing, but if neither the Trust Fund nor the aggrieved party can reach an agreement, the matter may, upon request of either party, be referred to the Mediation Unit of the State Board of Workers' Compensation.

This provision shall in no way enlarge the time period in which the employer/insurer must request a hearing to challenge the Trust Fund's denial before the State Board of Workers' Compensation.

(Rule 622-1-.06 amended April 2002 and December 2002)

RULE 622-1-.07 SETTLEMENTS SUBSEQUENT TO REIMBURSEMENT AGREEMENTS.

After the employer/insurer and the administrator of the Subsequent Injury Trust Fund reach an agreement with respect to reimbursement and the Reimbursement Agreement is approved by the State Board of Workers' Compensation, the employer/insurer shall keep the administrator of the Subsequent Injury Trust Fund informed as to any settlement discussion with the employee. The employer/insurer shall obtain the approval of the Subsequent Injury Trust Fund administrator on all settlements entered into for the employer.

RULE 622-1-.08 FUND NOT BOUND AS TO CERTAIN MATTERS.

Where the Subsequent Injury Trust Fund has been placed on notice of a potential claim against the Fund, the employer/insurer shall keep the Fund advised and cooperate with the administrator or his designee while defending the claim. Where the administrator or his designee acknowledges in writing that the Fund does not raise an objection to the manner in which the claim is defended or resolved, the Fund will not raise Code §34-9-366 as a defense to reimbursement liability by the Fund; provided, however, that the Fund reserves the right to intervene where the administrator or his designee deems it appropriate.

GLOSSARY

Active claim - a claim against the Subsequent Injury Trust Fund to be pursued immediately.

Administrator - person responsible for the daily management and operation of the fund.

Assessment - fee levied annually against Georgia's insurers and self-insured employers to fund operations and reimbursements of the Subsequent Injury Trust Fund.

Board of Trustees - five-member board appointed by the Governor to regulate the operations of the fund.

Claimant - injured employee.

Claims management responsibility - obligation for management of claim that falls on the employer/insurer.

Compensable injury - an on-the-job injury for which an employee is entitled to Workers' Compensation benefits and medical treatment as defined by Workers' Compensation laws.

Employer's Knowledge Affidavit - Form S.I. "H"; completed by employer indicating knowledge of permanent pre-existing impairment was established prior to the subsequent injury.

Employer's Request for Hearing - Form WC-14; completed by employer/insurer to request hearing on denied claim.

Group insurance records - supporting information in an employer's possession to help prove prior knowledge.

Hearing - legal proceeding before the State Board of Workers' Compensation to address legal questions and review the facts of a claim denied by the fund.

Inactive claim - claim against the fund to "toll the statute" only; that is, the employer/insurer merely reserves the right to pursue the claim in the future.

Indemnity benefits - compensation paid to the injured employee for loss of wages.

Industrial injury - an on-the-job injury.

Job modification records - supporting information in an employer's possession to help prove prior knowledge.

Medical benefits - injured employee's medical expenses paid to authorized providers.

Merger - circumstances in which a subsequent injury occurs due to the existence of a pre-existing, permanent impairment *or* which combines with the pre-existing impairment to create greater employer liability for disability, loss of wages, medical expenses, etc.

Notice of Claim - Form S.I."A"; completed by employer/insurer to initiate a claim against the fund.

Permanent impairment - condition due to a previous injury, disease or disorder, which is likely a hindrance to employment or re-employment.

Personnel actions - supporting information in an employer's possession to help prove prior knowledge.

Physical examination reports - supporting information in an employer's possession to help prove prior knowledge.

Pre-existing (or prior) impairment - see *permanent impairment*.

Processing time - amount of time needed to process an active claim.

Reimbursement checks - See *reimbursement*. Checks are issued twice a month.

Reimbursement - payment made to employer/insurer upon request, after claim has received final approval by the fund and the State Board of Workers' Compensation.

Reimbursement agreement - legal document outlining the fund's acceptance criteria and reimbursement schedule, subject to the approval of the State Board of Workers' Compensation.

Reimbursement Request – Form S.I."C"; submitted by employer/insurer to generate reimbursement from the fund.

Settlement - agreement between employer/insurer and the injured employee regarding lump-sum payment of employee's remaining claim.

Sick leave records - supporting information in an employer's possession to help prove prior knowledge.

State Board of Workers' Compensation - State-authorized board governing worker's issues. (a.k.a.: Workers' Compensation Board)

Subsequent injury - compensable on-the-job injury to a permanently impaired worker.