WORKERS' COMPENSATION LAW

Fall 2025 Section Newsletter

Luanne Smith, Co-Editor
Jenny Chapin, Co-Editor

Chairman's Corner

By: Ben Vinson, *Chairman and Chief Appellate Judge, SBWC*

Greetings from the State Board of Workers' Compensation. Hope everyone is having a great fall and enjoying football season. Go Dawgs. We are having a successful year in 2025 so far at the State Board. We hosted our regional seminars in three cities this spring and put on our Annual Educational Conference in Alpharetta this summer, including the 3rd annual Insurance Adjuster Training Program. All events were well attended and provided excellent programming and opportunities for those who participated. We also recently held the annual meeting of Advisory Council and then took part in the State Bar Workers' Compensation Law Institute on Jekyll Island. I am grateful to all who assisted by attending, speaking, or organizing these meaningful annual traditions. I had lots of important conversations on the coast and really enjoyed spending time with many of you there. Special thanks to Judge Sharon Reeves for co-chairing the WCLI seminar and to our administrative law judges for sharing insight and advice through their panel presentations. I would like to congratulate Alex Wallach for receiving this year's Distinguished Service Award from the State Bar of Georgia Workers' Compensation Law Section and to Wade McGuffey on being this year's recipient of the Dr. Tom S. Howell Memorial Award.

At the State Board, we continue to see increased activity with mediations and settlements. We are maintaining appropriate levels of staffing and focus on these important functions to be responsive to the needs of all parties. Additionally, we are updating and adding functionality to our information technology applications at the State Board. We are excited to implement a newly built Enforcement Division Information System ("EDIS"), and we are deploying a new automated online payment process to replace the current paper process. We remain committed to seeking and developing new technologies that will assist with efficiency and security while still providing a robust and accessible online claims management system.

As a recap of 2025 legislative issues, the Georgia General Assembly finished up the session and adjourned sine die on Friday April 4. Much of the focus this year was on tort reform, school safety, and as always, the state budget. We are grateful to Governor Kemp and our legislative leaders for supporting our agency in the state budget and throughout the legislative process. Here are more details on a few issues relevant to the workers' compensation system.

Peace Officers—HB105 was amended late in the session to add language from SB279 regarding the peace officer indemnification fund. We worked with Senator Brian Strickland on the best wording to accomplish the goal of providing notice to DOAS and the injured peace officer when the State Board believes a peace officer is eligible for the fund. HB105 passed both chambers and was signed into law by Governor Kemp on May 8. We are coordinating on the specific notice procedure to assist injured peace officers in the best manner possible.

PEO—HB250 passed the House and remains in the Senate Insurance committee for next year. We

facilitated discussion on this issue in Advisory Council and received very helpful feedback. HB250 is based on a model act for professional employer organizations ("PEOs") and includes a few provisions that raise concerns for different stakeholders in our industry. Fair comments were delivered at the different committee hearings and we will continue to follow this issue into the next session to find out if any form of regulation for PEOs is possible.

Longshore Act—HB574 and SB321 were introduced and remain in their respective committees for consideration next year. Both bills seek to shift Georgia law from concurrent state and federal jurisdiction to exclusive federal jurisdiction for injured longshoremen. We have discussed this issue at Advisory Council a couple of times in the past, so we are in a good position to study it again in detail and be prepared for further consideration as the legislative process plays out. I created a special subcommittee of our Licensure Committee to gather information and facilitate this process to be responsive to the General Assembly.

Finally, please join me in congratulating Judge Tasca Hagler on her retirement and Judge Andrea Mitchell on her return to private practice. We wish them the best and sincerely thank them for many years of service to the State of Georgia and our workers' compensation system. Feel free to contact me anytime directly with questions or comments about the Board or any other matter. And for the latest updates and information, please visit our website at https://sbwc.georgia.gov.

Inside This Issue

The Intersection of Employment Laws and Workers' Compensation: A Practical Guide for Employers and Employees

By: Daniel Cole

Whether an employer, employee, or attorney, we can often get hyper-focused on the task at hand. Work injuries are no different. Employers may open themselves to significantly more exposure by disregarding other employment laws that intersect with workers' compensation claims, and employees may overlook additional protections available to them under those laws. Workers' compensation claims provide attorneys with an opportunity to add value to clients. Defense attorneys can help employers navigate compliance with various employment laws—providing cross-marketing opportunities internally if at a full-service firm—and claimant-side attorneys can help issue-spot employment claims that may prove to be more valuable than the workers' compensation claim.

Let's use Jane Doe as an example. Jane has worked for Georgia Widget, Inc. for 2 years as a salaried employee in the Inbound Shipping Department. Georgia Widget is a large manufacturer with 600 employees onsite. In September 2025, Jane was walking through the warehouse when some strobing lights cause an epileptic seizure. Jane fell and hit her head on a safety rail, causing a concussion, laceration, and other head injuries. Jane was taken to the ER for treatment and was hospitalized overnight.

Upon discharge, the physician instructed Jane to take 1 week off of work and to follow-up with a neurologist. The insurer for Georgia Widget denies treatment, asserting that the epileptic seizure and subsequent injuries were not related to or caused by work. Jane engages a workers' compensation attorney to seek approval of her claim and subsequent treatment related to her head injuries. Frustrated that Jane is pushing the workers' compensation issue and going to miss some time from work, Georgia Widget decides to terminate Jane.

What started as an alleged work injury is now a landmine field of other claims for Georgia Widget. What claims should the employer, employee, and attorneys be thinking about at this point?

Family Medical Leave Act (FMLA)

The FMLA provides federal protections to employees dealing with personal illnesses or injuries. See 29 U.S.C. §§ 2601-2654. For reference, the FMLA also provides leave protections for illnesses or injuries related to eligible family members (e.g. spouse, child, or parent), the birth of a child and bonding, and military-related leave, among other reasons. For Jane, we are simply focused on her personal illness or injury caused by her injury at work.

Not all employees are eligible for FMLA leave. To qualify for FMLA, an employee must have worked for an employer for at least 12 months and worked 1,250 hours during the prior rolling 12-month period. Further, the location where the employee works must be large enough to qualify for FMLA leave. Employers who have 50 or more employees within a 75-mile radius trigger FMLA requirements—though employers can choose to offer FMLA leave to all employees as a benefit or to simplify administrative compliance. Triggering FMLA can also get nuanced based on the issue and type of treatment, so not all minor injuries or illnesses are FMLA eligible. If an employee is hospitalized or taken fully out of work for 3 days or more within 7 days of injury and has continuing treatment, FMLA is typically triggered. Once triggered, an employee can take up to 12 weeks of unpaid leave during a rolling 12-month period. Employers can offer paid leave concurrently with FMLA under benefit programs or allow use of PTO concurrently with FMLA.

Jane worked for Georgia Widget for 2 years, and Georgia Widget has well over 50 employees onsite. She was both hospitalized overnight and was taken out of work for a week and told to follow up with a neurologist. Accordingly, Georgia Widget should have considered Jane's FMLA rights before terminating her. When an employer has reasonable knowledge that an employee may be eligible for FMLA leave, the employer has a duty to notify the employee of their FMLA rights and to provide information relating to the FMLA leave process. Georgia Widget's termination of Jane opens it up to claims of FMLA interference for failure to notify Jane of her FMLA leave and terminating her when she otherwise would have had protected FMLA leave. Now, under the FMLA, Jane may be able to file a federal lawsuit under the FMLA and seek back-owed wages, benefits, and other economic damages, reinstatement or front pay, liquidated damages, and attorneys' fees and costs.

Further, some employees may have episodic medical events or ongoing treatment that may make them eligible for intermittent FMLA leave. FMLA does not have to be taken concurrently and can be used as needed when flare-ups happen or for ongoing treatment as needed. It is important for employers to have good attendance and record keeping systems to track use of FMLA leave and/or intermittent FMLA leave. Though employees may have FMLA protections, it does not mean that an employee cannot be terminated for legitimate reasons. If an employee clearly engaged in unsafe activity, caused an accident, or violated other rules or policies, the employee can still face discipline, including up to termination.

Americans with Disabilities Act/Americans with Disabilities Amendments Act of 2008 (ADA/ADAAA)

As a result of Jane's accident, Georgia Widget also learned about Jane's epilepsy diagnosis. It is imperative for employers to also consider potential issues under the Americans with Disabilities Act (ADA) and Americans with Disabilities Amendments Act of 2008 (ADAA) during work injuries, especially if it is clear that a work injury may relate to an employee's disability. See 42 U.S.C. § 12101 et seq. Employers cannot take adverse actions against an employee because of their disabilities. Likewise, employers have a duty to provide reasonable accommodations for disabilities under the ADA.

By terminating Jane within days of learning about her epilepsy, Georgia Widget opened itself to a claim of disability discrimination. The timing of the termination could certainly raise a reasonable inference that Georgia Widget made the decision to terminate Jane after learning about her disability. Georgia Widget would face responding to a charge of discrimination filed with the Equal Employment Opportunity Commission (EEOC) through a position statement and possible subsequent litigation if the EEOC or Jane elected to move forward with claims under the ADA/ADAA.

In addition, Jane may have a claim that Georgia Widget failed to provide a reasonable accommodation related to her disability. Many courts have affirmed that short periods of leave can constitute a reasonable accommodation, and the 1 week of leave recommended by the discharging physician could very well qualify as a reasonable accommodation.

Under the original ADA, the stringent definition of a disability often precluded many work injuries from qualifying as a disability under the ADA in the Eleventh Circuit. Typically, acute injuries did not qualify as a disability, and many acute injuries would still have a difficult time qualifying as a disability under the ADAA. However, when the ADA was amended in 2008 with the ADAA, Congress broadened what classifies as a disability and, importantly, added that employees can be "regarded as" disabled. See 42 U.S.C. § 12102. This catch-all definition can often provide protections under the ADA/ADAA if employers regard an injured employee as disabled and terminate the employee because of that reason—unilaterally deeming them a liability or otherwise unfit to work.

The ADA/ADAA provides similar economic damages for lost wages and benefits, reinstatement or front pay, and other identifiable economic damages. More importantly, the ADA/ADAA provides for additional damages not available under the FMLA: 1) compensatory damages for emotional distress, anxiety, humiliation, and other similar symptoms and 2) punitive damages for egregious conduct by an employer done with malice or reckless indifference to employee's rights under the ADA/ADAA. Those compensatory and punitive damages can range (through jury awards) between $50,000 - $300,000, depending on the size of the employer. See Remedies for Employment Discrimination, https://www.eeoc.gov/remedies-employment-discrimination; 42 U.S.C. § 12188. Like the FMLA, employees can also recover reasonable attorneys' fees and costs for ADA/ADAA claims. Therefore, it is important for employers to consider ADA/ADAA issues before taking steps with an injured employee.

OSHA Retaliation

Georgia is 1 of approximately 12 states in the country that do not have an anti-retaliation statute under its Georgia workers' compensation laws—meaning that Georgia offers little to no protections under state laws to private employees who are injured at work through no fault of their own. But, that does not mean that employers can completely disregard anti-retaliation protections. The Occupational Safety and Health Act (OSH Act, 29 U.S.C. § 658) is governed by the Occupational Safety and Health Administration (OSHA), tasked with overseeing a variety of statutes that provide anti-

retaliation and whistleblower retaliation protections for employees. OSHA also oversees a variety of safety laws and regulations. OSHA bars employers from retaliating against employees for engaging in the workers' compensation process or filing a workers' compensation claim.

Under OSHA, employees have a surprisingly limited time to file a claim of retaliation under the OSH Act: 30 days. Other whistleblower retaliation statutes have a longer statute of limitations to file claims. While other whistleblower retaliation statutes permit employees to bring a private right of action, employees who file OSHA retaliation claims are largely at the mercy of OSHA to bring or pursue those claims. Due to limited staff and resources, OSHA routinely declines to pursue claims on behalf of employees who may have been retaliated against, but OSHA has recovered 6-figure damages against employers for retaliating against employees who were simply injured on the job. Accordingly, employers should be clear in their reasoning when terminating an employee and have solid evidence that it is not simply due to the work injury, for engaging in the workers' compensation system, or to deter other employees from reporting work injuries.

Fair Labor Standards Act (FLSA)

While not directly related to the work injury, wage and overtime issues can be easily flagged during the workers' compensation process. Employers are required to provide wage records as part of establishing the Average Weekly Wage. Often, those wage records may show that employees are working well over 40 hours a week and not being paid proper overtime wages. The FLSA requires that most non-exempt employees be paid time-and-a-half their regular wage rate for any hours over 40 hours per week. See 29 U.S.C. § 201 et seq. Sometimes, it is clear that an employee earning $10 an hour continues to be paid only $10 an hour for hours worked over 40, instead of $15 an hour. Other times, employers mistakenly believe that just because an employee is salaried that they are not entitled to overtime.

In the case of Jane, she is a salaried employee, let's say $80,000 a year. If Jane is primarily working on the shipping floor doing manual labor, not managing 2 or more employees, and not meeting the requirements for a variety of other exemptions under the FLSA, she may be entitled to overtime wages despite being salaried. If Jane routinely works more than 40 hours a week but did not receive any additional pay beyond her salary, there is a possibility Georgia Widget owes Jane back-owed overtime wages, liquidated damages, and the attorneys' fees and costs that would be incurred pursuing claims under the FLSA.

Further, when an employer has failed to pay 1 employee overtime wages, you can almost bet that the employer failed to pay an entire class of employees overtime wages. FLSA claims are often brought as collective actions on behalf of entire classes of employees. In Jane's case, what started as frustrations with an employee who was injured on the job could turn into a large, 7-figure (or more) problem for the employer. FLSA claims are typically brought in federal court, and the US Department of Labor (USDOL) can also oversee overtime issues under the FLSA. The FLSA allows employees to reach back a minimum of 2 years for back-owed overtime wages and often 3 years for willful violations where the employer knew or should have known the employee(s) was entitled to overtime wages.

In addition to overtime wages, the FLSA governs minimum wages as well. Attorneys can use the workers' compensation process to ensure that employees are also being paid at least minimum wage for all hours worked. Sometimes flat fee compensation and long hours can create minimum wage issues.

Conclusion

Attorneys on both sides of the "v" can provide significant value adds to their clients by issue spotting other legal issues related to or intersecting with workers' compensation claims. Employers can avoid costly mistakes or correct problems before they become larger problems. Employees may identify alternative issues that could be more valuable than the work injury itself while also ensuring they are receiving the protections afforded to them under various employment laws.

This is a non-exhaustive list of potential claims that attorneys should consider, but it is representative of those that most often overlap with workers' compensation claims. There are entire books and bodies of case law dedicated to these employment laws, so these are merely intended to flag common legal issues for consideration. Having good processes and systems in place and good guidance from employment attorneys can avoid very costly and time-consuming mistakes during a workers' compensation claim. If injuries occur

in other states, there may be other state law claims to consider, potential whistleblower retaliation claims that could be triggered under various federal laws, and other local, state, or federal laws. Therefore, it is always best to assess each matter on a case-by-case basis and to discuss with attorneys specializing in these areas.

Like the Boy Scout motto: Be Prepared

By: Melodie Belcher

When I was asked to write an article about lawyers not being prepared for hearings my immediate reaction was, "Wow, I do not want to be the old judge complaining about young lawyers." But because I have a real problem saying no, I agreed to write the article despite my misgivings. I must admit, I am always happy to see seasoned lawyers at hearings – lawyers who have tried many claims and who I am confident know exactly what they are doing. On the other hand, when I see new lawyers (or at least new to trying claims), I am pleasantly surprised when they do appear to know how to try a claim, because that is not always the case.

Things have changed dramatically in the years since I was a new lawyer. Due to the popularity of mediation, and perhaps for other reasons as well, not many claims are tried anymore. Instead of trying at least one claim a month, and sometimes multiple claims in one week, lawyers are trying one claim a year. The end result is that new lawyers are not observing or handling hearings, because hearings just do not happen often enough. Not only did new lawyers try claims early and often in years past, but before they tried a case on their own, they generally went with a seasoned lawyer who guided them through the process the first time. It is rare now to see two lawyers at a hearing, one as the mentor and the other learning how the process works.

Of course, workers' compensation is not rocket science, and while the issues may be complex, they are often straightforward – simple factual disputes. But sometimes it is the seemingly straightforward claim that causes the most concern at a hearing. The lawyers do not anticipate evidentiary issues. They are unaware of possible defenses or theories of the claim. They do not understand burden of proof. They forget to prove necessary elements or to raise affirmative defenses. And, when something does not go as planned, the lawyer's confidence collapses or the lawyer is unable to maintain a professional demeanor, exhibiting anger, frustration, or impatience.

So, what is the goal when you are retained to represent a client? It is usually a financial question. You are looking to obtain income benefits and payment of medical for an injured worker or you are trying to minimize the cost of a claim for an employer/insurer. From the very start of representation, you are balancing your efforts and the costs with the likelihood of success. You must decide whether it is worth the cost of taking depositions or engaging in extensive discovery, whether it is worth the cost of independent medical examinations or second opinions, whether it is worth tracking down elusive witnesses, and whether it is worth pursuing surveillance. You also need to understand the difference between your clients' wishes and the reality of the likely outcome. If you represent injured workers, this may include the need to be heard, despite the possibility of a negative outcome. If you represent employer/insurers, this may be the need to take a stand, again, despite the possibility of a negative outcome. Once all these factors have been considered, in many cases, the appropriate approach may be pre-hearing settlement. However, you cannot rely on the idea that a claim will settle to disregard the need to plan for a hearing.

So, here are some specific suggestions to avoid appearing unprepared or unprofessional at a hearing:

1. Be able to tell the story. Ultimately, the judge will decide the claim based on who tells the best story - that is - a story that is rooted in fact and based on law. To do so, you must understand the issues and defenses. Discuss the claim with a co-worker to ensure that you are not missing the big picture by focusing on facts that are unlikely to matter to the outcome. Use discovery with intention, that is, with the specific aim of finding evidence to support your position. But at the same time, acknowledge evidence that is contrary to the outcome you desire. Understand the strengths and weaknesses of your claim prior to the hearing and discuss this with your client.

2. Review relevant statutes and case law, and if appropriate, bring copies to the hearing. Make sure WC-14s accurately state what you are seeking. If you represent employees, do not request TTD, TPD, and PPD to be paid at the same time starting with the date of injury. Your clients are not entitled to all these benefits at the same time and making this request blurs the issues. If the issues on the original WC-14 change, file updated WC-14s/WC-14(a)s. If you represent employer/insurers, check the Board file and make sure

that filings have been made as required. If the Board file is missing a document – a WC-1, WC-2, or WC-3, fix the problem before the hearing. Understand the consequences of not filing documents properly. If there are minor claimants in a death claim obtain a conservator prior to the hearing. Know who you represent and make sure your fee contract reflects the appropriate party. If you represent employer/insurers, be able to identify the proper insurer and the proper claims office.

3. If there is something unusual about your claim, discuss this with the judge in advance. For example, if an injured worker poses a threat, the judge will want to know this in advance so appropriate security will be in place. If the injured worker or the employer witness will use an interpreter, the judge should be advised prior to the hearing. If there are witnesses that require specific accommodations, this should be communicated to the judge in advance. And please, respond to the emails asking about the status of a pending hearing.

4. Know what you want for your client and be able to verbalize exactly what you want the judge to find/order. Know who has the burden of proof on all issues. If you want temporary total disability benefits, be able to state the specific dates you want the benefits to start and/or stop. If you claim a change in condition for the better, know the exact date you want benefits to be suspended. If you are seeking reimbursement, know the amount you are seeking. If you are disputing a requested surgery, know the basis for the denial – either the surgery is unrelated to the work accident, or it is not reasonable and necessary – or both. Be able to state this at the beginning of the hearing. In a denied claim, the claimant's attorney should be able to name the doctor he or she is seeking to be named the authorized treating physician. If there are unpaid medical bills, the claimant's attorney should have them readily available or should have made an agreement in advance with opposing counsel that they will work this out if the claim is found compensable. If you are defending based on the statute of limitations or another affirmative defense, be ready to verbalize this at the start of the hearing. If there is a request for assessed attorney's fees and litigation expenses, be ready to make a statement (and it is perfectly acceptable to use notes or to read your statement). Lawyers lose credibility when they request litigation expenses that are not covered by O.C.G.A. § 34-9-108 (b) (4), for example, copying expenses or the cost of an independent medical examination.

5. Discuss stipulations with opposing counsel prior to the hearing. The defense attorney should be able to state the stipulations when asked. If there are extensive stipulations, have a written copy for the judge but also be prepared to read the stipulations into the record.

6. Raise evidentiary issues before the hearing begins. Be able to state specifically why a document or witness testimony is not admissible. Have statutory and/or case law to support your position. If you anticipate an objection to one of your documents, have authority to support admissibility. If you have an unusual evidentiary issue, discuss this with the judge during the pre-trial call.

7. Prepare your documentary evidence. The judges will usually tell you how they prefer exhibits to be submitted during a pre-trial call. Not all judges have the same expectations, but at a minimum, your documents should include page numbers, and it is helpful if you include an exhibit list. Do not include duplicates or illegible pages. If you are unable to read a document the judge is also unlikely to be able to read it. Be judicious when preparing your exhibits – that is, do not include documents that have no bearing on the issues to be addressed.

8. Draft questions for witnesses. It is better to refer to a legal pad of questions and to mark them off as you go than it is to forget a necessary element. However, you also need to be able to listen at the same time, so you are hearing the responses. The response may suggest a follow-up question you did not anticipate. You must be ready and willing to pivot and add questions when necessary. The prepared list of questions is important, but it is equally important to be able to move off that list when the testimony takes you in a different direction. Listen when opposing counsel asks questions and do not repeat the questions – especially when the questions are benign, for example, whether the employee went to high school or is married. Pay attention in the moment.

9. Review the hearing process with your witnesses prior to the hearing. Explain the likely questions they will face and talk to them about answering only the questions asked. Practice is a good idea. Witnesses generally believe they can handle cross-examination, but they are often caught off guard and either exhibit anger, frustration, or anxiety. At times, this is damaging to their position. While you should not be surprised by your clients' answers to questions, it occasionally happens. Do not be afraid to ask the judge for a moment

to review your notes or to regroup. That is perfectly acceptable, but a moment is a moment, not a half-hour.

10. Question witnesses in a composed and polite manner. There are no juries in workers' compensation hearings, so bluster and irritation serve no purpose other than to annoy the judge. Also, unless we ask for clarification, we understand the question and answer, and we do not need to hear the same question or answer three or four more times. Once is enough. We also read the hearing transcript when we write our awards, so we will see the question and response yet again. Be patient with pro se parties. Consider stipulating to facts that are not in dispute when the employee is pro se. If a witness is not responsive, do not badger the witness. Instead, ask the judge for help by stating an objection that the witness is nonresponsive. But do not give up if you want an answer. This is not the time to be shy. At the same time, if a witness answers, "I don't know," that is an answer and asking the same question three or four more times is unlikely to illicit a different response. Also, if opposing counsel is questioning your witness, pay attention and raise objections when appropriate. I am often surprised when a lawyer is badgering a witness and opposing counsel appears to be reading something rather than paying attention.

11. Write briefs that matter. They do not necessarily need to be long, but they are helpful if they cite to specific page numbers in medical evidence or in the transcript that support your position. The judges appreciate legal analysis when appropriate. A logical argument with supporting law and facts is helpful. What is not helpful or professional is bluster about fairness or unfairness.

12. Finally, less is often more. By that, I mean that narrowly focusing on the evidence that is relevant to the issues is generally a better approach than throwing everything at the dart board and hoping to hit a bullseye. Think about your claim as a story and tell the story – about an employee who is injured, about the failure of an employer to acknowledge the injury, about an employee who was not injured, about an employee who is better and able to work, about the suitability of work, about the need for medical treatment. How does the story go – is it logical, does it make sense, is it supported by facts and law, is it easy to understand, or is it confusing, convoluted, or lacking in support. Remember your audience – the ALJ, the appellate division, the Superior Court, or the Court of Appeals. An organized presentation of your story using the facts and the law to support the desired outcome is the approach to take.

Good luck and try claims.

Differentiating Traumatic and Atraumatic Rotator Cuff Tears

By: Bradley L. Young, MD

Background

The rotator cuff tendons connect the subscapularis, supraspinatus, infraspinatus, and teres minor muscles to the proximal humerus, allowing these muscles to flex, as well as internally and externally rotate the arm at the shoulder. A rotator cuff tear (RCT) can lead to pain, weakness, and loss of motion. The conundrum of many workers' compensation claims involves identifying the presence or absence of a causal relationship between a RCT and work-place incident.

The terminology utilized to describe RCTs in evidence-based literature and the medical record is unstandardized.[1]However, RCTs can be generally stratified into acute (traumatic) or chronic. Acute RCTs typically occur when the macroscopic structure of the tendon fails under a traumatic forceful load or a direct impact. Chronic RCTs, not from a single traumatic event, occur when the microscopic integrity of the tendon fails over time due to environmental factors, aging, or repetitive microtrauma. "Acute-on-chronic" RCT is a term commonly used to describe an acute worsening of structural injury to a tendon that already had signs of chronic degeneration, typically occurring at lower loads than are needed to tear a healthy rotator cuff.

A thorough clinical history, physical examination, and radiological investigation can help differentiate traumatic from chronic rotator cuff tears.

Differences in Clinical History

Acute, traumatic RCTs typically occur in younger or middle-aged patients following a distinct injury, such as a fall on an outstretched arm, direct blow, or a sudden heavy lift, and are often associated with reports of an immediate increase in pain, weakness, and loss of active shoulder motion respective to the action of

1 Pogorzelski J, Erber B, Themessl A, Rupp MC, Feucht MJ, Imhoff AB, Degenhardt H, Irger M. Definition of the terms "acute" and "traumatic" in rotator cuff injuries: a systematic review and call for standardization in nomenclature. Arch Orthop Trauma Surg. 2021 Jan;141(1):75-91. doi: 10.1007/s00402-020-03656-4. Epub 2020 Nov 1. PMID: 33130936; PMCID: PMC7815591.

the torn tendon.[2] Traumatic tears are more commonly associated with the patient reporting a sensation of "popping" oran immediate increase in pain, weakness, and loss of active shoulder motion respective to the action of the torn tendon.Traumatic tears are more commonly associated with the patient reporting a sensation of "popping" or "ripping" at the time of injury. Shoulder dislocations present a distinct clinical scenario, as studies have found that 32% of primary shoulder dislocations were found to have full-thickness rotator cuff tears. Increasing age and female gender were associated with higher tears rates in the setting of dislocation.[3]

In contrast, chronic, atraumatic RCTs develop gradually in older individuals due to degenerative tendon changes and repetitive microtrauma. Symptoms progress slowly over months to years, characterized by insidious onset of shoulder pain, often worse at night, and a gradual decline in strength and function. Patients may perceive that their worsening shoulder symptoms were related to a work place incident due to a sudden increase in vigor and strain needed for a certain activity at work that was more difficult due to their underlying pre-existing pathology; therefore, it is importat for clinicians to discern if there was a sudden change in work-related activities around the time that the pain started.[4]

Differences in Physical Examination

Both traumatic and atraumatic RCTs can present with weakness and pain upon loading the rotator cuff, as well as limited active motion. Acute, traumatic tears are more likely to be associated with ecchymosis along the arm, which occurs from bleeding caused by traumatic tissue injury; however, ecchymosis is not always present. There are few other physical exam findings unique to traumatic tears unless there is documented objective impairments in strength just prior to and after the inciting injury.

Muscle atrophy, or wasting, is a physical examination finding that may be observed in patients with chronic, atraumatic RCTs. Atrophy, or "wasting within the fossa," is not always present, but when it occurs, it reflects a loss of muscle mass due to prolonged tendon detachment, which disrupts normal muscle loading and leads to degeneration and volume loss over time. This process is often accompanied by fatty infiltration and decreased muscle mass and is more likely in larger and chronic tears.[5]

Radiological Differentiation

Radiographs, ultrasound, computed tomography (CT) with arthrography, and magnetic resonance imaging (MRI). The most common of these obtained on patients with RCT are radiographs and MRI.

Radiographs are typically obtained at the initial visit of a patient complaining of a work-related shoulder injury in order to assess for fracture, dislocation, or osseous pathology. Radiographs alone are not sensitive for identifying RCTs or reliable for differentiating between traumatic and atraumatic rotator cuff tears. However, certain radiographic findings can provide evidence that a RCT has a higher likelihood of being chronic, and atraumatic, rather than a new injury. These findings include superior migration of the humeral head and decreased acromiohumeral distance.[6] The aforementioned radiographic findings are the result of a large rotator cuff tear, which has allowed the humeral head to slowly subluxate superiorly in the glenohumeral joint over time, which can ultimately lead to degenerative arthritis. This phenomenon is known as RCT arthropathy.

MRI can more reliably distinguish between acute and chronic RCT. An acute RCT is more likely to be associated with a edema, fluid accumulation, near the myotendinous junction, and a wavelike or "kinking" appearance of the retracted rotator cuff. Conversely, chronic tears are characterized by atrophy and fatty infiltration of the muscle belly.[7] Specifically, the "Tangent Sign," which refers to a measurable low threshold of atrophy of the supraspinatous muscle belly within its fossa is an MRI finding associated with more

2 Patel M, Amini MH. Management of Acute Rotator Cuff Tears. Orthop Clin North Am. 2022 Jan;53(1):69-76. doi: 10.1016/j.ocl.2021.08.003. Epub 2021 Oct 28. PMID: 34799024.

3 Berbig R, Weishaupt D, Prim J, Shahin O. Primary anterior shoulder dislocation and rotator cuff tears. J Shoulder Elbow Surg. 1999 May-Jun;8(3):220-5. doi: 10.1016/s1058-2746(99)90132-5. PMID: 10389076.

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chronic tears.[8] Although originally described based on CT-arthrogram, the Goutallier Classification, which is now commonly used while reading MRI, stratifies fatty infiltration of the muscle belly grade 1-4 based on the fat to muscle ratio seen on sagittal views. Generally, a higher fat to muscle ratio correlates with longer tear chronicity.[9]

Tables & Figures

Table 1. Distinguishing Features of Traumatic vs Chronic Rotator Cuff Tears

Feature	Traumatic (Acute)	Chronic (Degenerative)
History	Sudden onset, identifiable injury (fall, lift, dislocation)	Insidious onset, progressive pain/weakness
MRI	Muscle edema, tendon "kinking," minimal atrophy	Atrophy, fatty infiltration, tendon retraction
Radiographs	Often normal	Decreased acromiohumeral distance

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Case Spotlight: City of Atlanta v. Sebastian Clarifying the ATP's Authority, A Full Perspective

By: Will Warihay, Morgan and Morgan & Andrea R. Mitchell, Richter, Head, Shinall White & Slotkin

Case Summary and Background

In *City of Atlanta v. Sebastian*, the Georgia Court of Appeals reaffirmed the central role of the Authorized Treating Physician (ATP) in controlling medical treatment and determining work status under the Georgia Workers' Compensation Act.

Justin Sebastian, a City of Atlanta police officer, was injured in a 2017 motor vehicle collision while on duty. After initially treating with the City's ATP, Sebastian exercised his right under O.C.G.A. § 34-9-201(b)(1) to select a new ATP—orthopedic surgeon Dr. Craig Weil—from the employer's posted panel. Dr. Weil maintained light-duty restrictions. However, a referral specialist later issued a "full duty" release, and the employer/insurer relied on that opinion to unilaterally suspend Sebastian's weekly income benefits.

At the trial level, the Administrative Law Judge reinstated benefits and awarded attorney's fees, finding the suspension improper because it was based on a referral doctor's report, not the ATP's. The Appellate Division and Fulton County Superior Court affirmed. The City appealed to the Court of Appeals.

The Court of Appeals affirmed the reinstatement of benefits and attorney's fees. The court recognized that the statutory scheme, as well as the corresponding Board rules, distinguished between authorized treating physicians and referral physicians. The wrinkle in practice is that referral physicians are "authorized" to treat, but that "authorization" does not turn them into *the* authorized treating physician or the "primary" authorized treating physician. The court held that an employer/insurer may not suspend indemnity benefits based solely on a full-duty release from a referral or consulting physician unless that physician is *the* authorized treating physician. Because Dr. Weil—*the* actual ATP—had not released Sebastian to full duty, the suspension was unauthorized.

Injured Worker's Perspective

From the Claimant's standpoint, *Sebastian* strengthens the statutory and procedural safeguards surrounding the ATP relationship. The ATP remains the exclusive gatekeeper for return-to-work determinations for purposes of a unilateral suspension of benefits. A referral physician's opinion—no matter how specialized—does not carry authority to terminate income benefits unless the ATP adopts it. The case underscores the importance of ensuring all physician changes and authorizations are properly documented and filed with the Board.

From an argument and strategy standpoint, the Claimant's counsel can rely on *Sebastian* to challenge unilateral suspensions that bypass the ATP or rest on inconsistent medical opinions. Claimant's counsel are advised to prepare and keep written confirmation of who the ATP is at all stages of the claim, including, as discussed further below, properly filing WC-200a agreements with the Board when necessary. If benefits are suspended improperly, Claimant's counsel should file a prompt motion to reinstate benefits if a suspension is based on a non-ATP report.

The Court's opinion emphasizes that the evidence required is specific because of the impact a unilateral suspension of benefits can have on an injured worker. Nothing in the Court's opinion prevents the Employer/Insurer from seeking a change of condition for the better suspension of benefits based on a referral physician, through the proper course of litigation. However, in order for the Employer/Insurer to unilaterally suspend income benefits without an ALJ finding a change of condition for the better (via hearing or motion), they must have the proper medical evidence to do so, and it is on us as Claimant's practitioners to hold Employer/Insurer's to this requirement.

Employer/Insurer's Perspective

For Employers, Insurers, and defense counsel, *Sebastian* should remind or reinforce that when it comes to a unilateral suspension, following the procedure set forth in Board

Rule 221(i)(4) is imperative. And the law is now clear the language "employee's authorized physician" means the *primary* authorized treating physician who has been selected to manage the injured worker's overall medical condition. A "full duty" opinion from a referral physician or an IME physician is insufficient to justify unilateral suspension of benefits. Unilateral suspensions based on any opinion other than that of *the* ATP will result in reinstatement of benefits from the date of the improper suspension, as well as the risk of late payment penalties and assessed attorney's fees under O.C.G.A. § 34-9-108(b).

From a strategic perspective, Employers should channel any conflicting medical opinions through the ATP or ask an Administrative Law Judge to weigh in via motion or a hearing request. Yes, those avenues take time, but the alternative could lead to increased exposure for late payment penalties and assessed attorney's fees. Indeed, all mechanisms to reduce exposure, including setting a claim up for a statutory change in condition under O.C.G.A. § 34-9-104 or offering a light duty job under O.C.G.A. § 34-9-240, require the opinion of *the* ATP. So, before proceeding with a unilateral suspension of income benefits, Employer/Insurers should ensure that the doctor providing a full-duty release is *the* current ATP.

Similar to Claimant's counsel, the Employer/Insurer and its attorney should be motivated to maintain a clear record of selection of the initial ATP in a claim, along with any subsequent changes in care, referrals, and WC-200a's showing treatment authority. Often, treatment moves from an occupational clinic to a specialist, and that specialist will, for all intents and purposes, take over treatment. However, without a formal agreement, the occupational clinic remains the ATP. Arguments of "acquiescence" may not be as strong as they used to be. Accordingly, whether the parties want the specialist to be *the* ATP or even when a Claimant is exercising a one-time panel change, filing a Board Form WC-200a will clear up any confusion as to who can issue full duty releases that can result in unilateral suspension of benefits.

When faced with an opportunity for unilateral suspension of benefits, defense attorneys should advise their clients that the law is clear–unilateral suspension of benefits can only be legally accomplished with a full or regular duty release by *the* authorized treating physician. Employer/Insurer's should be counseled early and often that the correct way to use a referral physician's opinion or the opinion of IME physician to suspend benefits or reduce exposure is through the court by arguing for/requesting a change in condition for the better via motion and/or an evidentiary hearing.

Former Administrative Law Judge's Perspective

As a former Administrative Law Judge who was on the bench when this case made its way through the courts, I feel confident in stating that my former colleagues and I all believed that indemnity benefits could only be ***unilaterally*** suspended based on the opinion of *the* authorized treating physician. Cutting off an injured workers' benefits, especially without an actual return to work, is serious because it affects that individual's money – a substantive right. That said, the word "the" is not consistently used throughout the Code or the Rules when referring to the doctor charged with coordinating care as contemplated by the Workers' Compensation Act and upon whose opinion practically everything medical-related is based. With the Court of Appeals decision in *City of Atlanta v. Sebastian*, at least one area of potential inconsistency has been resolved.

Indeed, *the* ATP serves an extremely important role in workers' compensation and, as such, his or her identity should be clear. There is even a form for that – the WC-200a, mentioned several times already. This form puts everyone on notice as to the identity of *the* authorized treating physician and having one in the Board's file should clear up any confusion not only when it comes to unilateral suspension of benefits, but who can approve a light duty job or when a WC-104 should be filed. Indeed, this former ALJ often looked in the Board's file for a WC-200a.

Notwithstanding the foregoing, outside of things like unilateral suspension of benefits, neither party should make the mistake of always solely relying on the ATPs opinion. When a case gets before an Administrative Law Judge on other medical issues, say compensability of certain medical treatment, while *the* ATP's opinion will absolutely be considered, it will not always carry the day. As one ALJ often says, "The ATP's opinion is just that, an opinion." But if you are going to unilaterally suspend, make sure you only do that on the opinion of *the* authorized physician.

Conclusion

City of Atlanta v. Sebastian underscores what many think is a straightforward but critical principle: only "*the"* Authorized Treating Physician can close the door on indemnity benefits unilaterally without the involvement of the State Board of Workers' Compensation. For both sides of the bar, this case is a reminder that when practicing workers' compensation in Georgia, getting the right doctor's signature is as important as the diagnosis or opinion itself.