What Happens When Workers' Compensation Medical Treatment Is Delayed or Denied in Georgia?

A Treatment Recommendation Doesn't Always Mean the Appointment Gets Scheduled

A doctor says you need an MRI, physical therapy, an injection, a specialist, or surgery. Then nothing happens. The adjuster doesn't call back. The medical office says it's waiting on authorization. Or the insurer sends a denial and the treatment stops even though your symptoms haven't.

For an injured worker, that gap can feel like an administrative problem. Under Georgia workers' compensation law, it can be much more than that. The State Board's rules say an employer and insurer have a duty to provide reasonable and necessary medical treatment in a timely manner and to give appropriate help in contacting providers when necessary.

The response to a delay depends on what's actually being disputed. Is the entire claim denied? Has the authorized treating physician recommended care but the insurer hasn't acted? Is the insurer saying the treatment isn't medically necessary, or is it arguing that the treatment is unrelated to the work injury? Those distinctions determine which burden of proof and which Board procedure may apply.

What Medical Treatment Does Georgia Workers' Compensation Have to Provide?

Under O.C.G.A. § 34-9-200, an employer must furnish medical, surgical, hospital, and other treatment that is prescribed by a licensed physician and that the State Board determines is reasonably required and appears likely to cure the injury, give relief, or restore the employee to suitable employment.

That can include far more than a first visit to an occupational clinic. Depending on the injury, workers' compensation medical benefits may involve diagnostic imaging, specialist consultations, surgery, physical or occupational therapy, medication, medical equipment, follow-up care, and reasonable travel expenses connected with authorized treatment.

For most non-catastrophic injuries occurring on or after July 1, 2013, the general medical-benefit period is 400 weeks from the date of injury. Catastrophic injuries are treated differently, and the statute also creates continuing exceptions for certain prosthetic devices, spinal cord stimulators, intrathecal pumps, durable medical equipment, orthotics, corrective eyeglasses, and hearing aids that were originally furnished within the applicable period.

That timing point matters. The 400 weeks are measured from the date of injury, not from the date an insurer finally authorizes a disputed procedure. A long treatment dispute can therefore consume part of the period in which a non-catastrophic worker would otherwise be receiving care. Workers whose injuries qualify as catastrophic under Georgia workers' compensation law aren't subject to that same 400-week medical limit.

A Delay and a Denial Aren't Always the Same Thing

A provider saying “we’re waiting for workers’ comp” doesn’t tell you what has happened legally. Sometimes the insurer hasn’t received the physician’s documentation. Sometimes it has received the request and hasn’t responded. Sometimes it has formally controverted the treatment. And sometimes the entire workers’ compensation claim is being denied.

Georgia’s current Board rules give different procedures for those situations. The table below shows several of the most common treatment roadblocks.

What’s happening	What Georgia’s rules say	What may happen next
Authorized doctor recommends treatment, but the carrier stays silent	If the employer/insurer has had documentation of the authorized provider’s recommendation for at least 5 business days and still hasn’t authorized it, Rule 205 allows a WC-PMT petition.	A show-cause telephonic conference can be scheduled before an ALJ on an expedited timetable.
Provider sends a WC-205 request for advance authorization	The insurer/self-insurer must respond within 5 business days. If it doesn’t, the requested treatment/testing stands pre-approved.	If initially refused, the insurer generally has 21 days from receipt to authorize it or file a WC-3 specifically controverting the treatment.
Carrier says the treatment isn’t reasonably necessary	Under Rule 205(d), the employer/insurer bears the burden when the dispute is whether the treatment is reasonably necessary.	Medical records and the authorized doctor’s reasoning become central to the dispute.
Carrier says the care is unauthorized or unrelated to the work injury	Rule 205(d) places the burden on the employee when the dispute is authorization or causal relationship to the compensable injury.	The medical referral chain, diagnosis, and causation evidence may need to be developed.
The worker needs a different doctor or additional treatment	A one-time panel change may be available without approval. Other changes can be made by agreement or by Board order under § 34-9-200 and Rule 200.	The parties may use WC-200a by consent or WC-200b when agreement can’t be reached.
The entire claim is controverted	While the claim is controverted, the employer/insurer can’t restrict the worker’s treatment to the posted panel or WC/MCO.	If the claim is later accepted or found compensable, the worker can select a qualifying doctor who treated the work injury to become the authorized treating physician.

The right procedure depends on whether the overall claim is accepted or controverted, who recommended the treatment, and the stated reason for the delay or denial.

Preauthorization Isn’t Generally Required, but the WC-205 Process Can Matter

One of the more counterintuitive parts of Georgia workers’ compensation is that advance authorization is not generally required by the Act as a condition for payment of treatment rendered by an authorized provider. In practice, though, medical offices often want written approval before scheduling an expensive MRI, injection, or surgery because they don’t want to risk a later payment fight.

An authorized medical provider can use Form WC-205 to request advance authorization for treatment or testing. The request goes directly to the insurer or self-insurer with supporting

medical documentation. The current rule requires a response within five business days. If there is no response in that period, the treatment or testing stands pre-approved.

If the insurer sends an initial written refusal within those five business days, it doesn't get an unlimited amount of time to leave the request in limbo. Within 21 days of initially receiving the WC-205, the insurer must either authorize the treatment in writing or file a Form WC-3 with the Board controverting the treatment and stating the specific grounds.

That's why the paper trail matters. "The adjuster never called us back" is very different from proof showing the date the recommendation, supporting documentation, and WC-205 were actually delivered.

The WC-PMT Process Can Put an Unanswered Treatment Request in Front of a Judge Quickly

Georgia also has a separate WC-PMT procedure for recommended medical treatment or testing that hasn't been authorized. When an authorized medical provider has recommended the care, the employer or insurer has had documentation of that recommendation for at least five business days, and authorization still hasn't been provided, the employee or the employee's attorney may file a petition asking the Board to require an explanation.

The petition asks for a show-cause telephonic conference before an Administrative Law Judge. Under Rule 205, the conference is to be scheduled no more than five business days from the petition. The employer/insurer can authorize the treatment before the conference or formally controvert it and state the reason.

After the conference, the judge may issue an interlocutory order addressing authorization. A party that objects can request a hearing within 20 days, and that hearing request stays the interlocutory order. That makes WC-PMT useful for moving a stalled request forward, but it doesn't mean every disputed treatment recommendation is automatically approved.

Why the Reason for the Denial Changes Who Has to Prove What

A generic "denied" can hide a critical legal distinction. Georgia Board Rule 205 assigns the burden of proof differently depending on the insurer's stated reason.

- **Treatment Is Allegedly Unnecessary:** If the insurer accepts that the treatment is related and authorized but argues that it isn't reasonably necessary, the employer/insurer bears the burden on that issue.
- **Treatment Is Allegedly Unauthorized:** If the dispute is that the provider or treatment wasn't properly authorized within the workers' compensation system, the employee bears the burden.
- **Treatment Is Allegedly Unrelated:** If the carrier argues that the requested MRI, surgery, therapy, or other care isn't causally related to the compensable work injury, the employee bears the burden of establishing that relationship.

Those aren't interchangeable defenses. A denial based on "you don't need surgery" presents a different case from a denial based on "this surgery is for a condition that wasn't caused by the

work accident." A workers' compensation analysis starts by identifying exactly which dispute the carrier is raising.

What If the Entire Workers' Compensation Claim Has Been Denied?

When the employer or insurer denies the entire claim, the medical-treatment rules change in an important way. Board Rule 201 says the employer/insurer can't restrict the employee to its panel of physicians or WC/MCO while the claim is controverted.

If the claim is later accepted or the Board determines it is compensable, the worker may select one of the physicians who provided treatment for the work-related injury before that acceptance or decision. After notice to the employer, that doctor can become the authorized treating physician, and the employee may then make one change from that physician without employer approval or a Board order.

That distinction is easy to miss. A worker whose entire claim is denied is in a different position from someone with an accepted claim who simply chooses to leave the authorized treatment system on their own. Our discussion of what happens when a Georgia workers' compensation claim is denied addresses the broader dispute over compensability.

A denied claim may also require a Form WC-14 to protect the claim and request a hearing or mediation. The State Board describes a hearing as a trial-like proceeding before an Administrative Law Judge who decides what benefits, if any, should be awarded.

What If the Authorized Doctor Won't Treat You or You Need a Different Physician?

Sometimes the carrier hasn't actually denied a procedure. The problem is that the authorized treating physician won't schedule another appointment, has released the worker from care, or doesn't believe any more treatment is needed.

Georgia's physician-selection rules give an injured worker some options, but they depend on whether the employer maintained a valid panel or WC/MCO and whether the worker has already used the available one-time change. Under O.C.G.A. § 34-9-201, an employee using a traditional panel generally may make one change to another physician on the same panel without prior Board authorization.

Additional changes or treatment can be handled by agreement or Board order. If the parties agree, Form WC-200a can memorialize the change. If they can't agree, Rule 200 uses Form WC-200b, supported by the reasons and documentation for the requested change. An objection to a WC-200b request generally must be filed within 15 days of the request's certificate of service.

If the employer failed to provide a legally compliant method for selecting a physician, the worker may have broader rights to choose a doctor. That's one reason the posted panel shouldn't simply be assumed valid.

Emergency Care Is Different From Simply Going Outside the System

An injured worker shouldn't assume that any doctor they choose will automatically be paid by workers' compensation just because the authorized system is moving slowly. Unauthorized treatment can create its own payment dispute.

Georgia law does, however, recognize emergencies and other compelling circumstances. O.C.G.A. § 34-9-200(d) provides that when an emergency arises and the employer fails to provide the required care, or compelling reasons force the employee to seek temporary care, the employee may obtain necessary temporary treatment. The Board can order the employer to pay the reasonable cost.

Once the emergency passes, the normal physician-selection rules may again become important. Someone who has just been hurt at work should also follow the basic reporting and medical steps outlined in our Georgia workplace injury guide rather than waiting for symptoms or paperwork problems to resolve themselves.

Treatment Delays Can Affect More Than the Medical Side of the Claim

Medical care and income benefits are separate categories, but they often depend on the same medical record. An authorized treating physician may decide whether the worker can return to full duty, needs restrictions, or should remain out of work. If appointments, imaging, or specialist referrals stall, the work-status record can stall with them.

That can matter when an injured employee is seeking workers' compensation wage benefits or when an employer is offering light-duty work. Georgia's return-to-work procedures rely heavily on the authorized physician's current restrictions and approval of suitable work.

For example, a worker may still have significant symptoms but no updated restriction because the follow-up visit hasn't been authorized. That doesn't automatically establish entitlement to income benefits, but it shows why a treatment delay can create consequences well beyond the missed appointment itself.

Keep a Timeline of Every Treatment Request and Response

Medical disputes become much easier to evaluate when the dates are clear. Instead of relying on repeated phone calls and memory, injured workers should preserve the records that show what was recommended and what happened next.

- **The Medical Recommendation:** Keep the office note, referral, prescription, imaging order, or surgical recommendation from the authorized provider.
- **The Date It Was Sent:** Preserve fax confirmations, portal messages, emails, letters, and any documentation showing when the carrier or employer received the request.
- **The Carrier's Response:** Save written approvals, denials, WC-205 responses, explanations of the stated reason for refusal, and messages asking for additional documentation.
- **Scheduling Attempts:** Document calls to the medical office and any statement that an appointment can't be scheduled without workers' compensation approval.
- **Changes in Symptoms or Function:** Tell the treating doctor when a delay is affecting pain, mobility, sleep, medication needs, or the ability to work. The medical record is more useful than a later reconstruction from memory.
- **Out-of-Pocket or Group-Health Payments:** Keep bills, receipts, and insurance explanations of benefits if another payer covers care while compensability is disputed.

If another health carrier or provider pays for treatment while a workers' compensation claim is pending, Georgia has procedures that can allow a qualifying payer to seek reimbursement. That is another reason not to discard billing records simply because the immediate treatment crisis has passed.

Can an Insurer Face Consequences for an Unreasonable Medical Denial?

Not every disagreement over treatment is unreasonable. Insurers can dispute whether care is necessary, authorized, or related to the compensable accident, and Georgia law sets out procedures for resolving those disputes.

But O.C.G.A. § 34-9-108 allows an Administrative Law Judge or the Board to assess attorney's fees against a party when proceedings are brought, prosecuted, or defended in whole or in part without reasonable grounds. Georgia courts have applied that provision in cases involving unreasonable denials of medical treatment.

The Workers' Compensation Act is also the place where the remedy for an improper treatment delay generally has to be pursued. Georgia's Supreme Court has held that even an intentional delay in authorizing medical treatment doesn't create a separate common-law lawsuit against the employer or workers' compensation carrier when the Act provides remedies and penalties for that conduct.

Don't Let an Informal Treatment Dispute Sit Until a Deadline Becomes the Bigger Problem

A medical delay can feel temporary: the adjuster is reviewing it, the office is resending the request, or everyone is waiting for one more report. But workers' compensation deadlines continue to run while those conversations are happening.

The right filing deadline depends on what benefits have already been provided, whether the claim has been accepted, the date of the last authorized treatment or income payment, and the specific benefit being sought. The State Board advises injured employees to file a claim to protect their rights when benefits aren't being provided. Prompt reporting and attention to workers' compensation deadlines can matter even when the injury itself was reported long ago.

That's also why someone with a denied or stalled claim shouldn't assume that repeatedly asking the adjuster for treatment is the same thing as filing the correct Board form.

Our Georgia Workers' Compensation Lawyers Can Help Move a Medical Dispute Forward

When treatment stalls, the first job is identifying the real reason. Maybe the provider never sent the documentation. Maybe a WC-205 deadline has passed. Maybe the carrier has formally controverted the procedure. Maybe the authorized doctor needs to make the referral, or the entire claim is being denied.

Our Georgia workers' compensation lawyers can review the panel of physicians, medical recommendations, authorization history, Board filings, and carrier communications to determine what procedure applies. We can also pursue a change of physician or additional

treatment, request a WC-PMT show-cause proceeding when appropriate, or ask for a hearing when the dispute can't be resolved informally.

If medical care for your Georgia work injury has been delayed or denied, contact Gary Martin Hays & Associates for a free consultation. We can help you understand why the treatment has stalled and what options the Georgia workers' compensation system may provide.