GOODMAN McGUFFEY LINDSEY & JOHNSON LLP

LEGAL UPDATE

January 2010

Atlanta
3340 Peachtree Road, NE
Suite 2100
Atlanta, GA 30326-1084
Telephone: 404.264.1500
Facsimile: 404.264.1737

Orlando
201 S. Orange Avenue
Suite 1010
Orlando, FL 32801-3477
Telephone: 407.478.1247
Facsimile: 407.478.1527

Savannah
530 Stephenson Avenue
Suite 300
Savannah, GA 31405-5987
Telephone: 912.355.6433
Facsimile: 912.355.6434

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Should *Maloney* Apply in Today's Economic Environment?

By Teri Zarrillo and Jeffrey Stinson

There is little doubt that claimants, employers, insurers and counsel for all in the workers' compensation legal community have seen changes in practice as the economy has fallen. Statistics show that claims actually should decline during bad economic times. As a practical matter, however, it seems that workers' compensation litigation actually has increased.

Whatever the reasons for the changes in the frequency and/or type of workers' compensation claim and/or litigation, we, as attorneys, rely on the consistent application of case law precedent in our practices. At the same time, we must realize that the realities of our times will inevitably affect the judges' decisions in cases. Perhaps there is a fine line between accepting facts to support an award of benefits and failing to require claimants to satisfy legal requirements for entitlement to benefits? In practice, it seems that this fine line is being blurred to extinction when looking for a claimant to meet their burden of proof for entitlement to income benefits in certain cases.

Georgia workers' compensation law is well settled that a claimant who has work restrictions or limitations due to his on-the-job injuries and who is terminated for cause and for reasons unrelated to his on-the-job injuries has the burden of proving an inability to find suitable employment due to his injuries despite a diligent job search before he will be entitled to weekly temporary total disability (TTD) benefits. *Maloney v. Gordon County Farms*, 265 Ga 825 (1995). What constitutes a diligent job search has been the subject of much litigation over the years, although Georgia courts have never really given a clear standard as to what qualifies as a "diligent" job search. In *Maloney*, the claimant's job search with six different employers was found to be diligent. In other cases where the job search was limited to only two fields of work, the Court of Appeals concluded the job search was not diligent. *Harrell v. City of Albany Police Dep't*, 219 Ga. App. 810 (1996). Although these cases give some guidance as to what qualifies as "diligent", in practice, the outcome depends on the ALJ and the facts of each specific case.

Initially, it seemed that the *Maloney* burden would be difficult for a claimant to meet. Not only was the claimant to be taxed with going out and looking for work within their restrictions and capabilities, but also they seemed to be required to prove that their inability to find work was due to their injuries, an approach advocated by the Court in *Aden's Minit Mkt. v. Landon*, 202 Ga. App. 219 (1991) However, over time, the courts clarified that a claimant would be presumed to have been denied work due to his injuries once he established that he performed a diligent job search. *Maloney, T.V. Minority v. Chaffins*, 223 Ga. App. 495 (1996). The claimant is not required to prove why he was not offered employment. *Sadeghi v. Suad, Inc.,* 219 Ga. App. 92 (1995). In practice, this presumption results in a shifting of the burden of proof back to the employer and insurer to show that the claimant was, in fact, denied work for reasons other than his injuries. Often times, employers and insurers are left to expend significant resources to produce testimony from the prospective employers of their reasons for denying a claimant employment. The employers' failure to produce this direct evidence would preclude them from proving that the claimant was denied employment for reasons other than their on-the-job injuries.

This apparent shifting of the burden of proof has seemed to erode the very purpose of the requirement that the claimant perform a diligent job search and show that his inability to find alternative employment was due to his injuries. Still, having the burden of proof forces claimants to show, at a minimum, that they are trying to find other work. With the changes in the economy, there is little doubt that a claimant today is going to have a more difficult time finding work than a claimant of just over a year or 2 ago. However, without any change in the case law, it seems that the unfavorable economy may be leading to the practical effect of eliminating the requirement that a claimant look for work at all before awarding income benefits, regardless of the reason for their termination from the employer.

The claimant's bar may argue that it is a waste of time for claimants to look for work when even able-bodied workers cannot find work. In fact, statistics show that the unemployment rates are near an all-time high, and certainly the highest in recent memory, with no ceiling in sight. The United States Department of Labor Bureau of Labor Statistics currently projects the national unemployment rate to be 9.5%. In Georgia, over the past year, the unemployment rate has risen from 5.9% in May 2008 to 9.7% as of May this year. We do not need to look far to find reasons for the unemployment rate, as companies ranging in size from large plants to small businesses are closing.

Such a narrow view is clearly misplaced. Focusing on only unemployment rates or the probability of claimants in general finding work ignores the specific capabilities of the individual workers. Furthermore, there is little doubt that the claimant's bar would object to eliminating the obligation to provide income benefits to an injured worker who is capable of working with restrictions anytime the economy is strong. The employer and insurer's argument would be that the claimant certainly should find work if he looked since the economy is so good, so he should not get benefits under any circumstances. How would we judge when the economy was at a state that called for application of the *Maloney* burden? When would we apply the burden of proof at all?

Although *Maloney* and the line of cases following it indicate that the economy should not have any impact on whether an injured worker who was terminated for cause should be required to conduct a diligent job search, recent decisions from the Board appear to question this well accepted principle. Specifically, in at least one recent case, (and there is some concern in the defense bar that this may be more widespread), an ALJ did not require a claimant to even look for work and instead summarily found that "dire economic circumstances" at least partially resulted in an employee's inability to find work. Notably, the ALJ relied upon decisions which pre-dated *Maloney* and its job search requirements. See, i.e., *Gilmer v. Atlanta Housing Auth.*, 170 Ga. App.

326 (1984) and *King v. Piedmont-Warner Development et al*, 177 Ga. App. 176 (1985). Certainly, dire economic circumstances may make it more difficult to find work, but such circumstances should not eliminate an employee's obligation to perform a diligent job search.

Additionally, looking only at the odds of a claimant finding work is ignoring other practical considerations for the *Maloney* burden. Remember that the workers' compensation system in Georgia is a no fault system. It was not designed to indefinitely support an injured worker, particularly one capable of returning to alternative employment. One does not need to look far to see clear examples of the legislature's attempt to motivate a claimant to return to the work force by limiting their entitlement to benefits: the 400 weeks statutory cap on entitlement to TTD benefits without a catastrophic designation (O.C.G.A. §34-9-261), stringent requirements before a claim is designated catastrophic (OC.G.A. §34-9-200.1), and the statutory change in condition OC.G.A. §34-9-104).

The Georgia Workers' Compensation Act was designed to ensure injured workers resources for medical care while at the same time ensuring that they would have income until they returned to the workforce. At the same time, the Act provided employers and insurers limitations on medical care and income benefits and eliminated suits in tort together with any claim for general damages. The court's decision in *Maloney* was consistent with the overall purpose of the Act. That is, since the *Maloney* burden only applies when the claimant is capable of some form of gainful employment, an employer and its insurer should not be required to keep that employee at work or provide them income benefits so long as the reason they are out of work is unrelated to their work-accident. If the claimant can otherwise work, the purpose of the Act is fulfilled and the claimant should not be due additional benefits.

Practically, reliance on the *Maloney* burden is even more important in a bad economy. The reality is that many employers are having an extremely difficult time keeping all of their employees employed. If the injured worker and his non-injured coworker are both terminated, they should both be required to look for work. Not requiring the injured worker to look for work, actually results in preferential treatment, possibly even arguable discrimination against the non-injured employee. Furthermore, there would be a very real concern that more frivolous workers' compensation claims would be made just to level the playing field so that workers' could guarantee some income to their families even without any need for them to look for work.

As with any issue, the parties, their counsel, judges and legislatures need to be cognizant of the impact of the changing economic times. At the same time, we must recognize the impact of the economy on legal issues for all. There is no question that employers and insurers are feeling the impact of the economic decline, as are employees. Legal precedent should be followed now as in good economic times to make sure we continue to pursue outcomes that support the purpose of the Workers' Compensation Act.

CASE NOTES

Georgia Liability

STATUTE OF LIMITATIONS: The statute of limitations for a personal injury action arising out of a crime – including a simple traffic offense – is tolled pending the prosecution of the crime.

Beneke v. Parker, 285 Ga. 733, 684 S.E.2d 243 (2009)

On April 27, 2005, Patricia Parker was injured when her car was struck from the rear and overturned by a vehicle driven by Alan Beneke. Beneke was cited for following too closely. Parker filed a personal injury action against Beneke on May 11, 2007 – two weeks after the expiration of the applicable two-year limitations period – and Beneke moved for summary judgment. The trial court, on motion for reconsideration, found that the complaint was timely-filed because the statute of limitation had been tolled until Beneke paid his ticket on May 19, 2005. For its holding, the trial court relied on OCGA § 9-3-99, which provides that the running of the limitations period for a tort action arising out of a criminal act is tolled from the date of the crime until the prosecution is terminated (or six years, whichever is less).

The issue before the Supreme Court was whether or not a citation for following too closely constituted a "crime" for purposes of the statute of limitations tolling provision. The Court of Appeals held that whether or not following too closely constituted a crime was a jury issue rather than a question of law. On this issue, the Supreme Court reversed, holding that a "violation of one of the Uniform Rules of the Road, such as the rule that a driver must not follow another vehicle too closely, is a misdemeanor . . . and a misdemeanor is 'any crime other than a felony.' Thus, the plain language of OCGA § 9-3-99 would encompass a violation of a Uniform Rule of the Road."

The Supreme Court expressed its own misgivings with this result, which it anticipated will "have a significant impact on personal injury actions arising out of vehicle accidents by tolling the statute of limitation in those situations where a traffic citation is issued." Nevertheless, the Court was constrained to strictly construe the statute, noting that, "[i]f the Legislature had intended to limit the application of [the tolling statute] to tort actions arising from only certain types of crimes . . . it certainly could have done so. It did not, and any undesirable result is a matter properly addressed by the General Assembly rather than the courts."

CIVIL PROCEDURE/FILING DEADLINES/OPENING DEFAULT JUDGMENT: Answer to complaint must be filed within 30 days of service. Once in default, unless party seeking to open default complies with specific requirements, trial court has no discretion to open default.

Cavender v. Taylor, 285 Ga. 724, 681 S.E.2d 139 (2009)

In 2008 the Taylors filed a complaint to quiet title of certain real property located in Hall County, Georgia. The complaint was served on Cavender on July 1, 2008, and he filed his answer on August 5, 2008. On August 21, 2008, the Taylors moved for default judgment based on Cavender's failure to file an answer within 30 days of service as required by O.C.G.A. § 9-11-12(a). After two hearings, neither of which Cavender attended, the trial court entered a default judgment in favor of the Taylors.

Relying on O.C.G.A. § 9-11-5(b), which provides that service by mail is complete upon mailing, Cavender argued on appeal that his answer was timely filed on July 26, 2008, the date he placed it with the United States mail, and therefore it was error to enter a default judgment. The Georgia Supreme Court disagreed, holding that the statutes provide that an answer shall be filed with the court within 30 days after the service of the summons and complaint. No provision is made for extending the time for filing an answer by mail.

Cavender also argued that the trial court erred by failing to open the default. Under O.C.G.A. § 9-11-55(b), a prejudgment default may be opened by a court, after payment of costs, for providential cause which prevented filing of the plea, for excusable neglect, or where a judge determines a proper case has been made for the default to be opened. There are four conditions precedent to opening default. The defendant must: (1) make a showing under oath; (2) offer to plead instanter, (3) announce ready to proceed with trial, and (4) set up a meritorious defense. Compliance with the conditions of O.C.G.A. § 9-11-55(b) is mandatory and in the absence of strict compliance, the trial court has no discretion to open a default.

In this case, Cavender did not move the court to open the default (either as a matter of right or before final judgment based on providential cause or excusable neglect), did not satisfy the four required conditions and did not pay costs. As a result, the Court ruled the trial court was without discretion to open the default and that it properly denied Cavender's request to open default.

LIBEL AND SLANDER: Person reporting another for child abuse is immune from defamation suit where reporting party had reasonable cause to make report.

Brown v. Rader, 299 Ga. App. 606, S.E.2d 16 (2009)

The Browns rented a house from the Raders for two years before a rainstorm caused serious flooding in the house. County Health Department worker Varn tested samples from the house and found mold. Varn told both parties that the Browns could not stay there until remediation was done, that they should only be inside the house for short periods and even then only if they wore face masks. Mrs. Rader agreed to release the Browns from paying rent that month, pay for alternate housing for them and pay for the remediation of the house.

Shortly thereafter, the Browns discovered that Mrs. Rader had reported to the Department of Family and Children Services ("DFACS") that she had seen the family in the house for up to six hours on several occasions after the report of mold was made and that their six-year old son did not wear a mask during those visits.

The Browns sued the Raders for defamation, emotional distress and breach of

contract, seeking damages, remediation expenses, three times their security deposit, attorney fees and punitive damages. The trial court granted summary judgment to the Raders on their claims for defamation, emotional distress, treble damages, attorneys' fees and punitive damages, but denied summary judgment on the claim for breach of contract. The Browns appealed the decision.

Defamation requires publication, which occurs when the slander is communicated to anyone other than the person slandered. The reporting statute, O.C.G.A. § 19-7-5, provides that persons making reports of abuse are immune from civil or criminal liability as long as the reports are made in good faith. The Supreme Court of Georgia has extended immunity under the statute to persons making a report with reasonable cause.

The Court of Appeals held that this is an objective standard; the specific intent of the reporting party does not matter. Mrs. Brown provided conflicting testimony as to whether or not her son was in the house without a mask; therefore, the Court held that Mrs. Rader had reasonable cause to make the report to DFACS. As such, the Court affirmed summary judgment on the claim for defamation, as well as attorneys' fees and punitive damages arising from the defamation claim.

Georgia Workers' Compensation

STATUTE OF LIMITATIONS: A request for catastrophic designation must be filed within two years of the last receipt of income benefits.

The Kroger Company et. al v. Wilson, 301 Ga. App. 345, 687 S.E.2d 586 (2009)

Wilson was a truck driver for The Kroger Company. In 1994 he injured his back and had spinal surgery. After two years, he returned to Kroger in a light duty capacity, and continued to work for 14 months.

He had back surgery gain in February 1998. In August he returned back to work at Kroger, but continued to have back pain. During his second return to work he had a sedentary position as a dispatcher. He worked fewer hours, until his doctor took him off work in May 2004.

Kroger paid Wilson temporary total disability benefits for the periods he was out of work and temporary partial disability benefits when he performed the light duty position. Wilson exhausted his entitlement to TPD benefits in September 2001.

In August 2003, Wilson filed a WC-14, Request for Hearing, seeking temporary total and/ or temporary partial disability benefits from September 2001 forward. He did not seek a catastrophic injury designation. He later withdrew the hearing request.

In April 2006, Wilson filed a WC-R1CATEE for catastrophic designation. The Administrative Law Judge found that the request was time-barred. Wilson appealed and the Appellate Division reversed the ALJ. The Superior Court affirmed.

However, the Court of Appeals reversed and reinstated the ALJ's Award. The Court held that a request for a catastrophic injury designation constitutes a request for change in status or condition pursuant to O.C.G.A. §34-9-

104(b) and such a request had to have been made within two years from the date of his last receipt of income benefits.

Since Wilson's claim was filed nearly five years after he last received income benefits his claim was barred. The Court further noted that the WC-14 filed in August 2003 did not toll the statute of limitations because it did not seek a catastrophic designation.

NOTE: A petition for certiorari is pending at the Georgia Supreme Court at press time.

APPELLATE REVIEW: The findings of fact made the Board must be accepted by the Courts in further appeals.

St. Joseph's Hospital et al v. Ward, 300 Ga. App. 845, 686 S.E.2d 443 (2009)

Ward filed a claim alleging four separate injuries over a period of years as a result of her work as a nurse for St. Joseph's Hospital. An ALJ found that Ward had sustained a compensable injury to her right knee in 2005. The ALJ further found that the claimant's last day of work qualified as a "fictional new accident" date as that was the date that the employee ceased work due to a gradual worsening of her condition. The ALJ did not make any findings as to whether Ward ever sustained an injury to her left knee in 2003.

The Appellate Division found that the alleged left knee injury was barred by the statute of limitations, and that the right knee claim was not compensable either, based upon the holding in *Chaparral Boats v. Heath*, 269 Ga. App. 339 (2004). The fictional injury claim was also denied as the Board found that Ward had only returned to work light duty for a brief time and that there was not any evidence that the work resulted in any subsequent trauma to an idiopathic right knee injury.

The Superior Court reversed the Full Board. In doing so they found that the Board misconstrued the ruling in *Chaparral Boats,* and that the "undisputed evidence" showed that there was a fictional new injury to the left knee on September 16, 2005, or in the alternative there was a new injury to the left knee on that date as the "undisputed facts" showed that Ward's right and knee condition worsened gradually due to her work activities.

The Court of Appeals found that the Superior Court exceeded its authority by rejecting the Board's application of *Chaparral Boats*. The Court held that the Superior Court and higher appellate courts must defer to the facts found by the Board because the "fact finding body in each case must be the final arbiter of the compensability of the injury." *Harris v. Peach County Board of Commissioners,* 269 Ga. App. 225 (2009).

The Court of Appeals also reversed the Superior Court's findings that the undisputed evidence showed that there was either a new injury or a fictional new injury on September 16, 2005. In doing so, the Court of Appeals noted that there was a factual dispute, and the Superior Court erred by reversing the Board's factual findings.

Georgia
Coverage

BAD FAITH and the "SAFE HARBOR" PROVISION: An insurer may not utilize the "safe harbor" provision to prevent bad faith liability when it places conditions on a settlement offer which are within that insurer's control.

Fortner v. Grange Mutual Insurance Company, 286 Ga. 189, 686 S.E. 2d 93 (2009)

Cecil Fortner was injured in a car accident caused by Alan Arnsdorff. Arnsdorff had a policy with Grange with bodily injury liability limits of $50,000 and his plumbing business had $1,000,000 in liability coverage with Auto Owners. Fortner offered to settle all claims for $50,000 from Grange "contingent upon" Auto Owners' payment of $750,000. Auto Owners did not respond to the demand. Grange responded that it would pay $50,000 contingent upon Fortner "signing a full release with indemnification language" and dismissing his claim against Arnsdorff with prejudice.

Fortner considered this a rejection and went to trial where he won a $7 million verdict against Arnsdorff. Arnsdorff then assigned to Fortner any cause of action he might have against Grange based on its alleged bad faith in refusing to settle Fortner's claim brought against him. The jury returned a verdict in favor of Grange in Fortner's bad faith claim.

Fortner appealed the verdict contending that the trial court erred in giving the following jury charge: "In responding to a settlement demand, which demand is conditional upon the response of another insurance company, an insurance company can offer its policy limits in response to the demand and then let the plaintiff negotiate with the remaining insurers. In that situation, the insurance company would have given equal consideration to its insured's financial interest and fulfilled its duty to him."

The COA found this charge was consistent with the "safe harbor" provision explained in Cotton States Mutual Insurance Company v. Brightman, 276 Ga. 683 (2003). The "safe harbor" provision states that an insurer is not in bad faith when the plaintiff makes a settlement offer containing a condition that is beyond the control of the insurer. In short, the provision protects an insurer from liability under the reasonableness standard under such circumstances.

The Supreme Court granted certiorari to consider whether the COA property interpreted the "safe harbor" provision.

The Supreme Court reversed the COA. In its analysis, the Supreme Court focused on Grange conditioning its acceptance of Fortner's offer to settle on his signing a full release of Arnsdorff with indemnification language and dismissing his claim against Arnsdorff with prejudice. Effectively, this condition would have required Fortner to forego any claim against Arnsdorff and would potentially forfeit his access to the Auto Owners policy. As these conditions were clearly ***within*** Grange's control, the Supreme Court found that the jury should be allowed to consider these circumstances in determining bad faith and the "safe harbor" provision would not be applicable.

SPOLIATION OF EVIDENCE: Litigation must be contemplated or pending before sanctions for destruction of evidence may be warranted.

Silman v. Associates Bellemeade, 286 Ga. 27, 685 S.E.2d 277 (2009)

In July of 2004, Meredan Silman was a guest at the home of Lamar and Nancy Scott when the Scotts' deck collapsed, injuring Silman. Nearly two years after the incident, Silman and her husband sued the Scotts, who were renting the house, along with the property management company and property owner. The trial court granted summary judgment in favor of the property management company and owner, finding there was no evidence they had knowledge of any defects in the construction of the deck. The trial court also declined to award sanctions against these defendants for rebuilding the deck and thereby destroying evidence necessary to prove the Silmans' case. The Court of Appeals affirmed and the Silmans appealed to the Supreme Court, arguing that case law bars the destruction of evidence in cases where there is any "potential for litigation."

The Supreme Court unanimously affirmed the decisions of both lower courts, finding that the phrase "potential for litigation" refers to litigation that is actually "contemplated or pending" at the time the evidence is altered or destroyed. Since the Silmans did not file their lawsuit until almost two years after the deck collapsed, no presumption arose that the deck repair was done with the intent of destroying harmful evidence. There was "no evidence showing that litigation was pending or contemplated when Bellemeade had the deck debris removed." Consequently, sanctions for spoliation of evidence were not warranted.

PREMISES LIABILITY: Residential landlord faces liability for failure to install smoke detectors pursuant to O.C.G.A. § 25-2-40.

Gordon v. Fleeman, 298 Ga. App. 662, 680 S.W.2d 684 (2009)

Fleeman and Barnhart died as a result of a fire at the duplex they subleased from Dessesseau, who leased the duplex from its owner, Gordon. Fleeman and Barnhart resided in one side of the duplex, and their bedrooms were upstairs. After the fire Fleeman was found upstairs in a bathtub, while Barnhard was found upstairs in his bed.

Fleeman and Barnhart's relatives and estates filed suit against Dessesseau and Gordon, alleging that Gordon was negligent for failing to install smoke detectors in the duplex as required by O.C.G.A. § 25-2-40. Section 25-2-40(a) states, in pertinent part, that "every dwelling … constructed prior to July 1, 1987, shall have installed an approved battery operated smoke detector which shall be maintained in good working order." The jury found Gordon and Dessesseau liable for Fleeman and Barnhard's deaths and after judgment was entered on the verdicts, Gordon appealed.

At trial, Gordon testified he had purchased the duplex in approximately 1998 and leased it to Dessesseau in April of 2004 for use as housing for individuals with mental and/or physical disabilities. As part of the lease agreement, Dessesseau and a contractor inspected the duplex and made a list of all necessary repairs. Gordon then delegated the responsibility and authority to make all such repairs to Dessesseau. With respect to smoke detectors, Gordon testified that they were supposed to have been installed, although he personally never purchased or installed any smoke detectors, or even walked through the duplex to confirm that smoked detectors had in fact been installed.

The fire investigator testified that during his investigation he found no evidence of either a smoke detector or a "backing plate," which is a mount for smoke detectors which is typically

attached to walls or ceilings with screws. In his defense, Gordon called the contractor who testified he specifically recalled Gordon purchasing smoke detectors and telling the contractor to install them in the duplex. The contractor testified further that he did in fact install smoke detectors in Fleeman and Barnhart's unit.

The Court of Appeals held this testimony from Gordon and his contractor did not mandate a finding that the smoke detectors had been installed as required by O.C.G.A. § 25-2-40, but merely created an evidentiary conflicts which was for the jury to decide. The jury was not required to believe Gordon or the contractor's testimony. Other testimony, such as that of the fire investigator that no smoke detectors or backing plates had been found in the duplex, authorized the verdict for the plaintiffs.

PREMISES LIABILITY: Invitee cannot recover for injury resulting from static hazard on sidewalk where invitee has successfully negotiated hazard on previous occasion.

James v. Sirmans, 299 Ga. App. 262, 683 S.E.2d 354 (2009)

James was injured when she fell on the concrete in front of a beauty shop in Pearson, Georgia. James arrived at the beauty shop for an appointment late in the afternoon. She stepped over the curb and entered the shop through the front door. Her appointment lasted about an hour, and outside the shop it dry and well-lit when she exited. After taking a few steps out of the shop, James planted her foot to step down into the parking lot, and she stepped on a "cracked piece of concrete" and fell.

James sued the owner and the operator of the beauty shop. The evidence showed that the beauty shop had operated in its current location since 2004. James acknowledged that she had visited the shop in that location "two or three times" prior to the date of her fall and that each time she entered and exited the building through the same front door

The defendants filed for summary judgment, which the trial court granted. The Court of Appeals affirmed, relying on previous holdings of the Court that an invitee "is not entitled to an absolutely smooth or level way of travel. It is common knowledge that small cracks, holes and uneven spots often develop in pavement; and it has been held that where there is nothing to obstruct or interfere with one's ability to see such a static defect, the owner or occupier of the premises is justified in assuming that a visitor will see it and realize the risk involved."

Ms. James likened her claim to a prior appellate case where the plaintiff presented evidence that the fall occurred after she "left through a door she did not generally use, and she walked down a path that was not familiar to her." The Court of Appeals rejected this comparison, stating that, in addition to walking by the alleged defect in the concrete as she entered the beauty shop on the day of her fall, James admitted that she had used the same door to enter and exit the shop on at least two prior occasions within the past few months. James also acknowledged that her fall did not result from any foreign substance on the concrete, inability to see the crack as a result of darkness or obstruction, or distraction that prevented her from noticing the crack.

The court reiterated the most fundamental rule of premises liability law, that an owner or operator's liability is based on "superior knowledge of the existence of a condition that could subject the invitee to an unreasonable risk of injury." Given James' acknowledgment that the crack in the sidewalk "was pretty obvious to anybody walking in the door" and the fact that she had successfully negotiated the sidewalk on previous occasions; she was presumed to have knowledge of it and could not recover for her injury.

PREMISES LIABILITY: Business proprietor has duty, when he can reasonably apprehend danger to customer from misconduct of other customers or persons on premises, to exercise ordinary care to protect customer from injury caused by such misconduct.

Leo v. Waffle House, Inc., 298 Ga. App. 838, 681 S.E.2d 258 (2009)

One early morning Leo, a homeless person, was drinking coffee with three other customers at Waffle House Restaurant. Wilson, a salesperson for Waffle House, went behind the counter and poured a mixture of juice, hot water, lemons, sugar, Ivory soap and Score dishwashing detergent into an empty apple juice bottle. Wilson then challenged Leo to drink it. Leo initially declined, but then Wilson offered him five dollars if he drank it. At that point, grill operator Sparks walked by and stated "I wouldn't drink that, Leo, if I were you, but I'm not getting involved."

Despite this warning, Leo drank the mixture; he then collapsed on the floor and began foaming at the mouth. Wilson called 911, and Leo was taken to the hospital for internal injuries from the corrosive dishwater detergent.

Leo sued Waffle House, claiming that Waffle House was liable to him for the negligence of employee Wilson and for negligent supervision. Leo also claimed negligence for failure to intervene, because Sparks knew about the contents of the drink, but did not stop Leo from consuming it. Waffle House filed a motion for summary judgment, which the trial court granted.

On appeal, the Georgia Court of Appeals partially reversed. The appeals court determined that employee Sparks knew that Wilson had mixed the concoction using dishwater detergent and therefore had superior knowledge of the risk. Accordingly, it was for a jury to decide whether Sparks' failure to intervene constituted negligence.

On the other hand, the Court of Appeals agreed with the trial court with regard to Leo's claim for negligent supervision, finding that an employer may be held liable for negligent supervision only where there is sufficient evidence to establish that the employer reasonably knew or should have known of an employee's tendencies to engage in certain behavior relevant to the injuries allegedly incurred. Since it was not shown that Waffle House had actual or constructive knowledge of such a propensity on the part of Wilson, summary judgment was appropriate as to the negligent supervision claim.

The appeals court also affirmed the trial court ruling that Wilson was not acting within the scope of his employment with Waffle House and therefore that Waffle House was not liable under for Wilson's negligence.

INSURANCE COVERAGE/HOMEOWNERS' INSURANCE: Field approximately fifteen miles from insured's residence was not "insured premises" under homeowners' policy.

Mason v. Allstate Insurance Company, 298 Ga. App. 308, 680 S.E.2d 168 (2009)

Stowers was injured when she was thrown off an ATV owned by the Kralicks and driven by their daughter. The accident occurred at a field approximately fifteen miles from the Kralicks' home. The Kralicks had a homeowners' insurance policy through Allstate Insurance Company. Allstate denied coverage based upon an exclusion for bodily injury arising out of the ownership or use of any motor vehicle designed principally for recreational use off public roads when that vehicle is owned by an insured person and is being used away from an insured premises.

The policy defined "insured premises" as the residence premises and any premises used by an insured in connection with the residence premises. The insureds argued that the exclusion

was ambiguous. The trial court granted summary judgment in favor of Allstate and the Court of Appeals affirmed.

Whether a policy is ambiguous is a matter of law for the court's determination. The court applies the rules of contract construction to resolve ambiguities. In construing an insurance policy, the test is what a reasonable person in the insured's position would understand the words of the policy to mean. The policy should be read as a layman would read it and not as it might be analyzed by an insurance expert or an attorney. If a policy term is susceptible to two or more different interpretations, the term is ambiguous and strictly construed against the insurer who drafted the policy.

The ATV was owned by the insureds and was a motor vehicle designed principally for recreational use off public roads. The question the Court of Appeals resolved was whether the field where the accident occurred was an "insured premises" as that term was defined in the policy. The accident did not occur on the insured's residence premises, on property owned or leased by the insureds, on property where the insureds had an easement, on roads or property adjacent to the insured's residence, or on roads or property surrounding the insureds' home that were necessary for ingress or egress or otherwise necessary for the insured's enjoyment of their home. The Court of Appeals considered several cases noting these various factors and concluded that the field at issue in this case was not being used in connection with the residence premises.

Stowers' parents also argued that the field was being used in connection with the "residence premises" because the insureds were holding their daughter's birthday party in the field. The Court of Appeals declined to apply this construction, reasoning that to do so would unreasonably expand the coverage under the policy.

NEGLIGENCE/INSURANCE BROKER LIABILITY: Insurance broker is not liable to insured for failure to procure full coverage where insured has actual knowledge of coverage (or lack thereof) or where policy terms are plain, unambiguous and readily apparent.

Four Seasons Healthcare, Inc. et al. v. Willis Insurance Services of Georgia, 299 Ga. App. 183, 682 S.E.2d 316 (2009)

Four Seasons Healthcare, Inc. and several other businesses and individuals hired Willis to procure directors and officers liability insurance to cover all claims that might arise from a particular business transaction. Willis procured two AIG policies to cover the insureds in the business transaction. Once the business transaction was completed, a block of shareholders sued the insureds claiming they were wrongfully frozen out of the stock purchase and transfer of corporate assets.

AIG denied the claim under both policies. Four Seasons' claim was excluded for prior acts and the other insureds' claim was excluded because the shareholders' claim was brought by more than 5% of the insured's voting stock. None of the insureds challenged the denial; rather, the insureds pursued a negligence claim against Willis for failing to procure the proper insurance coverage. The trial court granted summary judgment to Willis and the insureds appealed.

Where the agent does procures the requested policy and the insured fails to read it to determine which risks are covered and which are excluded, the agent is insulated from liability. The exception to this rule occurs when the agent holds himself out as an expert in the field of insurance and performs expert services on behalf of the insured under circumstances where the insured must rely on the agent's expertise to identify and procure the correct coverage.

The Court of Appeals found that Willis had given copies of the policies to the insureds

prior to the shareholder lawsuit. By having the policies in their possession, the insured were deemed as having knowledge of the policy provisions and under the general rule, Willis was insulated from liability. Four Seasons had also previously rejected prior acts coverage, so it had actual knowledge that prior acts were not covered by the policy.

The Court of Appeals also found that the exception to the general rule did not apply because Four Seasons had actual knowledge that prior acts were not covered by the policy. In similar fashion, the policy exclusion relied upon by AIG to deny coverage to the remaining insureds was plain, unambiguous and readily apparent. Therefore, the Court determined that the insureds were charged with the knowledge of the policy exclusions, barring recovery from Willis.

The Court of Appeals also determined that summary judgment was appropriate because the insureds failed to submit any evidence that the insurance policies could be purchased without the 5% major shareholder provision. Accordingly, the insureds could not prove Willis's actions were the proximate cause of the loss.

INSURANCE POLICY LIMITATIONS: Contractual time limitations on the right to bring an action are valid and will be enforced by the Courts.

Encompass Insurance Company of America v. Friedman, 299 Ga. App. 429, 682 S.E.2d 694 (2009)

Toby Friedman purchased an all-risk homeowner's insurance policy from Encompass Insurance Company of America in 1993. The all-risk policy meant that all damages that were not expressly excluded from the policy were covered. This policy was renewed annually by Ms. Friedman.

In September 2005, Ms. Friedman noticed that the den in her ceiling had gray discoloration around the light registers. The discoloration persisted and Comfort Air Heating & Air Conditioning was called to evaluate the problem. The representative from Comfort Air examined the home on September 2 and 6, 2005 and on the receipt noted "condensation on insulation causing ceiling damage" and recommended "replacement of all duct work because of … condensation thru-out duct work".

Ms. Friedman then contacted Byrd's Heating and Air, Inc. for a second opinion and in October 2005, a Byrd representative informed her that she might have a mold contamination problem. This was confirmed on October 21, 2005 by a mold expert from Professional Mold Services. The representative concluded the mold growth was caused by water condensate dripping from the air conditioning system duct work and from the lighting fixtures.

Ms. Friedman then called and reported the claim to Encompass the next day. After conducting its own investigation, Encompass denied the claim based on a policy exclusion regarding "defective design" of the HVAC system.

As result, on September 15, 2006, Ms. Friedman filed a lawsuit against Encompass for breach of contract, bad faith and bad faith attorney's fees. Encompass moved for summary judgment on two grounds: (1) Ms. Friedman's lawsuit was untimely filed under the limitation period contained in the policy; and (2) the damage fell within an exclusion of the policy.

The trial court denied summary judgment and the Court of Appeals granted Encompass's application for interlocutory appeal.

The Encompass policy included the following language: "No action [against Encompass] can be brought unless the policy provisions have been complied with and the

action is started … [w]ithin one year after the date of loss." The Court cited case law stating that contract limitations like this are valid and will be enforced by the Courts. Further, absent special circumstances such as waiver, estoppel, or impossibility, compliance with a suit limitation is generally a condition precedent to an insured's recovery.

Ms. Friedman argued the suit was timely filed because it was within one year of the date on which the mold contamination was confirmed. However, the Court found her argument misguided because the recovery sought was for the water damage and mold from the HVAC system – not for HVAC system itself. As the record was clear that Ms. Friedman knew of the damage prior to her calling Comfort Air on September 6, 2005, the Court found her suit, filed on September 15, 2006, was untimely filed outside of the one year limitation date on the policy.

As the Court found in favor of Encompass on the issue of timeliness of the suit, there was no need to reach the second issue regarding whether or not the loss was covered.

BAD FAITH/REFUSAL TO SETTLE: Insurer is not liable for bad faith/failure to settle claim in absence of verdict in excess of policy limits or agreed-upon settlement.

Trinity Outdoor, LLC v. Central Mutual Insurance Company, 285 Ga. 583, 679 S.E.2d 10 (2009)

In 2002, a billboard owned by Trinity Outdoor, LLC fell while it was being installed on Trinity's property, killing Anthony and Joshua Fowler. The billboard was manufactured by Phoenix Outdoor, LLC. Trinity, the owner, reported the accident and injuries to Central Mutual Insurance Company, with whom Trinity had a $2M general liability policy. Central hired separate counsel for both itself and Trinity and both counsel determined that Phoenix improperly installed a bolt on the billboard that broke before the accident. Trinity filed suit against Phoenix regarding the defective billboard and Phoenix did not oppose the claims, with Trinity recovering $754,530 from Phoenix and its insurance carrier.

The Fowler family sued Phoenix and Trinity, and Trinity cross-claimed against Phoenix for contribution and indemnity. A few months later, the Fowlers made a time-limited demand on Central to settle the case for its $2M policy limits. Trinity's counsel demanded Central accept the settlement to prevent exposure to an excess verdict. Instead of settling, Central filed a Motion for Summary Judgment on Trinity's behalf believing it had valid and strong arguments that Trinity was not responsible for the accident. At mediation, the Fowlers demanded $14M from all defendants. The litigation ultimately settled for $12M and of that amount, Trinity, without Central's approval, agreed to contribute $954,530, which included $200,000 offered by Central and the $754,530 Trinity had earlier received from its judgment against Phoenix.

Trinity sued Central for breach of its insurance agreement and bad faith refusal to settle in violation of O.C.G.A. § 33-4-6. The case was removed to the federal court and the district court certified the question to the Supreme Court of Georgia as to whether an action for bad faith failure to settle a case requires that a judgment first be entered against the insured in excess of the policy limits.

The court held that generally insurance companies are free to set the terms of their policies as they see fit as long as they do not break the law or public policy. In this case, the Central policy provided that " "[n]o insured will, except at the insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than first aid, without our consent." Since the parties agreed that Trinity's payment without Central's consent was a voluntary payment, Central was not legally

obligated to pay under the policy and Trinity was not entitled to seek reimbursement from Central of the money it paid in settlement.

Trinity contended that the provisions of the contract were unenforceable under Southern *Guaranty Insurance Co. v. Douse*, 278 Ga. 674 (2004), however, the court held that nothing in Douse made the insurance provisions in this case illegal or contrary to public policy. Rather, Central provided Trinity with a defense pursuant to an insurance contract which specifically stated that Trinity had no right to unilaterally settle any claim without Central's permission. Accordingly, Trinity could not maintain an action against Central for bad faith failure to settle in the absence of a jury verdict.

INSURANCE COVERAGE/UM STACKING: In cases of conflict between pre-printed and written portions of insurance policy, written portions will prevail.

State Farm v. Staton, 286 Ga. 23, 685 S.E.2d 263 (2009)

Cecil Staton was severely injured in an automobile collision in a vehicle owned by his employer, Smyth & Helwys, and insured by State Farm. The policy identified the "named insured" as the "first person named" on the declarations page. Smyth & Helwys was the first and only name listed on that page. Smyth & Helwys owned two other vehicles which were insured separately by State Farm, but which were not involved in the collision. These policies also identified Smyth & Helwys as the sole named insured on the declarations pages.

The UM coverage for each separate policy was $100,000. Staton wanted to stack the policies to provide UM coverage totaling $300,000. State Farm moved for summary judgment, arguing that Staton was not the named insured on any of the policies and that, therefore, he could seek UM coverage on the policy covering only the vehicle he was driving at the time of the collision. The trial court granted State Farm's motion for summary judgment and the Court of Appeals reversed due to an ambiguity in the policy, which defined a "person" as "human being," which Smith & Helwys clearly was not.

The Supreme Court reversed, concluding that the term "named insured" was unambiguous. The plain and ordinary meaning was readily apparent from the declarations pages; Smyth & Helwys was the only named insured on each of the policies. The Court further held that, to the extent the pre-printed portion of the policies (which defined a person as a human being) were in conflict with the written portion (the name appearing on the declarations), the written portion must prevail. "It is a well settled rule, in construing . . . policies of insurance, the main portions of which are printed and the special or particular portions adapting it to the precise agreement of the parties are written, that the written words should be given greater force and effect than those which are printed." Accordingly, Staton was not entitled to stack the UM coverage of his employer's other two auto policies.

Georgia
Underinsured/Uninsured Motorist

UNINSURED MOTORIST COVERAGE/EXHAUSTED COVERAGE: Hospital lien reduces amount of available bodily injury liability coverage for purposes of evaluating availability of UM coverage.

Floyd v. American Int'l South Ins. Co., 298 Ga. App. 771, 681 S.E.2d 216 (2009)

Floyd suffered injuries in a collision where both the driver and the owner of the other car were insureds of United Automobile Insurance Company. United paid its policy limits of $25,000 to Floyd in exchange for a limited release. Ms. Floyd sued the driver and owner for additional damages and claimed uninsured motorist coverage from American International South Insurance Company. American moved for summary judgment and argued that the driver and owner were not "uninsured."

The Georgia Code (as it existed prior to the 2008 amendment) defines an uninsured motor vehicle as one where the available liability coverage is less than the amount of the insured's UM coverage. See O.C.G.A. § 33-7-11(b)(1)(D)(ii). The Code only considers the motor vehicle uninsured for the amount of the difference between the available liability coverage and the limits of the uninsured motorist coverage.

However, the Code calculates the available liability coverage as the limits of coverage "less any amounts by which the maximum amounts payable under such limits of coverage have, by reason of payment of other claims or otherwise, been reduced below the limits of coverage." O.C.G.A. § 33-7-11(b)(1)(D)(ii). In this case, there was a hospital lien for treatment provided to Floyd, which had not been satisfied.

The trial court granted summary judgment to American because the difference between the amount of bodily injury liability coverage available and the limits of uninsured motorist coverage available was zero. This was based on the United policy limits of $25,000 and Ms. Floyd's American UM policy limits of $25,000.

The Georgia Court of Appeals reversed and remanded the case. In doing so, the Court of Appeals determined that Ms. Floyd's hospital lien reduced the amount of available liability coverage for the purpose of evaluating the availability of UM coverage under O.C.G.A. § 33-7-11(b)(1)(D)(ii)'s calculation. A previous case had determined that when the existing coverage was reduced due to paying a hospital lien, that this reduction could create an uninsured situation. The Court noted that the foregoing applies even where the hospital lien remains outstanding rather than paid. Thus, the Court determined that an outstanding lien reduces the available liability coverage in the same way a satisfied lien would.

NOTE: The Georgia Supreme Court granted cert in January, so this issue should be closely monitored.

CIVIL PROCEDURE/UNINSURED MOTORIST: UM carrier may be served for first time in renewal action even where reasonable belief that vehicle was uninsured existed in original action.

Retention Alternatives, LTD. v. Hayward, 285 Ga. 437, 678 S.E.2d 877 (decided June 1, 2009).

Hayward filed a personal injury action against the owner/operator of a vehicle after an auto accident. She voluntarily dismissed the suit without prejudice and filed a timely renewal action. A renewal action is a suit that has been re-filed within six months of the dismissal of an original action, allowing for a tolling of the statute of limitations back to the date of the filing of the original action.

Hayward served her uninsured motorist carrier for the first time in the renewal action. The UM carrier filed for summary judgment at the trial court level, alleging that the statute of limitations had run and the UM carrier had not been served within ninety (90) days of Hayward's knowledge that the injury causing vehicle was uninsured as was required by O.C.G.A. §33-7-11(d). The trial Court granted summary judgment in favor of the UM carrier.

The Court of Appeals reversed the trial court's grant of summary judgment based upon the Georgia Supreme Court's holding in *Stout v. Cincinnati Ins. Co.*, 269 Ga. 611 (1998). In *Stout*, the Georgia Supreme Court found that a UM carrier was timely served with process in a renewal action despite not being timely served in the original action.

The UM carrier in *Hayward* petitioned for certiorari, contending that it was error for the Court of Appeals to rely on *Stout*, supra, because *Stout* construed the pre-1998 version of O.C.G.A. §33-7-11(d).

The Georgia Supreme Court affirmed the Court of Appeals' ruling. It held that, since the language relied upon by the Court of Appeals in the pre-1998 version of §33-7-11(d) (providing that the UM carrier shall be served "as prescribed by law… as though the [UM carrier] were actually named as a party defendant") had been retained in the amended version of the statute, it was therefore appropriate for the Court of Appeals to rely on *Stout* and find that service of process on the UMC was timely, even though Stout was decided prior to the 1998 amendment.

Florida Workers' Compensation

QUANTUM MERUIT LIEN: When a prior attorney asserts a lien based on quantum meruit, the fee should be apportioned out of the attorney's fee paid to the claimant's current attorney.

Rosenthal, Levy & Simon, P.A. v. Scott, 17 So.3d 872 (Fla. 1st DCA 2009)

The claimant sustained injuries to her shoulders, wrists and hands and secured legal representation from the Rosenthal law firm. Before Rosenthal's services were terminated by the claimant, Rosenthal obtained an offer of $7,500 to settle the claimant's case. Three days later, the claimant's new attorney settled the claimant's case for $10,000. Rosenthal filed a charging lien and an evidentiary hearing was held in front of the JCC. Ultimately, the JCC

determined that Florida Statutes Section 440.34(1) only permitted fee entitlement to an attorney who secured benefits. The JCC reached this conclusion by deciding that the precedent established in *The Law Office of James E. Dusek, P.A. v. T.R. Enterprises*, 644 So. 2d 509 (Fla. 1st DCA 1994), did not apply to dates of accident after October 1, 2003.

The appellate court reversed and determined that the changes that were made effective October 1, 2003 did not affect a prior attorney's right to a charging lien in quantum meruit for services rendered in a workers' compensation matter when the prior attorney was discharged by the claimant. Specifically, the appellate court determined that the fee statue in place at the time *Dusek* was decided similarly limited an award of attorney's fees to situations where an attorney secured a benefit for the claimant.

The importance of this case is not only that the appellate court determined that a discharged claimant's attorney is entitled to a charging lien for quantum meruit, but the Court further explained how the value of the quantum meruit lien should be determined. The Court indicated that because the legislature limited the amount that could be awarded based on the value of the benefits secured, the JCC must apportion the fee between the discharged attorney and the successor attorney.

MISREPRESENTATION/FRAUD: Provision of a false Social Security number can constitute misrepresentation/fraud, if the intent of the claimant, as determined by the JCC, was to provide the false number in order to obtain benefits.

Arreola v. Administrative Concepts, 17 So.3d 792 (Fla. 1st DCA 2009)

The JCC in this case denied benefits to a claimant pursuant to a misrepresentation/fraud defense. Florida Statutes Section 440.105(4)(b) specifically prohibits any person to "make, or cause to be made" any false, fraudulent, or misleading statements for the purpose of obtaining workers' compensation benefits.

Here, the JCC found that the claimant provided a false Social Security number on at least three occasions: when the claimant was transported by ambulance to the hospital, at the pharmacy when obtaining prescription medication and on a telephone interview between the claimant and the E/C's investigator. Although the claimant did not provide the false Social Security number directly to the ambulance personnel, the JCC found that the claimant's co-worker provided it to the ambulance personnel at the claimant's direction. Without going into detail, the appellate Court determined that the aforementioned findings of the JCC were supported by competent substantial evidence.

The Court then addressed whether the claimant intended the statements to be made for the purpose of obtaining benefits. Although the claimant testified that he presented the number solely as a means for identification, the JCC ultimately determined, based on the credibility and demeanor of the claimant, that the claimant provided the false number for the purpose of obtaining benefits.

The appellate court affirmed the JCC's denial of benefits to the claimant and reiterated that "[i]n order to be self-executing, the statute requires the claimant's information to be truthful, responsive, and complete."

MEDICAL EVIDENCE: A JCC is free to reject even uncontroverted medical opinions that are determined to be non-persuasive.

White v. Bass Pro Outdoor World, 16 So.3d 992 (Fla. 1st DCA 2009)

The JCC was presented with two differing medical opinions regarding the major contributing cause ("MCC") of the claimant's knee injury. The claimant's authorized treating physician opined that the claimant's industrial accident was the MCC of the claimant's knee condition. The employer obtained an independent medical evaluation which initially agreed with the claimant's authorized treating physician. However, it ultimately indicated that he was unable to provide an opinion within a reasonable degree of medical certainty, one way or the other, on the issue of MCC after he was provided with medical records that demonstrated a prior problem with the claimant's affected knee.

The JCC rejected the opinion of the claimant's authorized treating physician and denied benefits to the claimant. The claimant appealed the JCC's Order asserting that the JCC provided an unreasonable basis for rejecting the opinion of his treating physician. The claimant specifically asserted that his treating physician's opinion was uncontroverted. The appellate court determined that although the employer's IME opinion was inconclusive, it established a medical foundation for questioning the medical validity or weight of the treating doctor's opinion.

The Court held that as finder of fact, a JCC is free to accept or reject the opinions of witnesses, even expert witnesses, which are found to be non-persuasive. Specifically, the Court stated that in making a determination as to the persuasiveness of an expert's opinion, the JCC can consider the "knowledge, skill, experience, training or education of the witness, the reasons given by the witness for the opinion expressed and all other evidence in the case."

A question raised in this instance is why the claimant did not request an Expert Medical Advisor ("EMA") be appointed. Had the claimant requested an EMA be appointed, he would have at least had a 50/50 chance of obtaining a favorable opinion. An EMA's opinions are deemed to be correct, absent clear and convincing evidence why they should be disregarded. However, by failing to request an EMA, claimant left the JCC with the ability to weigh the evidence presented and determine whether the claimant met his burden of proof.

ADMISSIBLE MEDICAL OPINIONS: A JCC has the authority to authorize a physician to provide a claimant with medical treatment

Parodi v. Florida Contracting Co., Inc., 16 So.3d 958 (Fla. 1st DCA 2009), decided August 21, 2009.

This case primarily concerned the JCC's refusal to consider the medical opinions of two doctors who provided treatment to the claimant during a period when the Employer/Carrier refused to provide medical care to the claimant.

Claimant sustained an injury to his right shoulder. Employer provided orthopedic treatment including surgery. The claimant was diagnosed with RSD, which spread to his right leg. Employer then authorized treatment with a pain management physician and a psychiatrist. In the mean time, the employer obtained records regarding claimant's prior accidents, so it denied all further benefits to the claimant based on major contributing cause ("MCC") and fraud. The claimant then requested treatment with a neurologist and pain management physician. After the employer denied these requests, the claimant sought it on his own. Ultimately, the claimant filed a Petition for Benefits requesting both temporary and permanent disability

benefits, as well as payment of the medical bills from the treatment the claimant sought on his own.

The JCC determined that the employer "forced" the claimant to obtain treatment on his own and awarded temporary indemnity benefits, also ordering the employer to pay the bills relating to the treatment the claimant had sought. However, the JCC excluded the opinions of the physicians the claimant had treated with on his own.

The appellate court determined that the JCC should not have excluded the opinions of the physicians that the claimant treated with on his own. Specifically, the Court held that when the employer provides a claimant with timely medical benefits as required by statute, the employer maintains control over who to authorize. However, when the employer fails to provide the claimant with treatment they are obligated to provide, the claimant is free to seek treatment from a physician pursuant to Florida Statutes Section 440.13(2)(c). The Court held that excluding the opinions of such physicians would render the aforementioned statute meaningless. Ultimately, the Court determined that when a JCC awards payment to a physician, he authorizes that physician and therefore, those opinions are admissible in the underlying claim.

Goodman, McGuffey, Lindsey & Johnson LLP
3340 Peachtree Road, NE
Suite 2100
Atlanta, GA 30326-1084

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