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HOW TO DEAL WITH THE OCTOBER 1, 2007 DEMISE OF PIP IN FLORIDA

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In the last issue of our GMLJ Legal Update, we addressed the demise of Florida's Motor Vehicle No-Fault Law, with a caveat that the Florida Legislature might revive the expired law while in special session. This anticipated revival now has occurred.

In the 2007C special session, the Florida Legislature reenacted Florida's No-Fault Law, though it has several differences from the former law. The enactment amends several Florida Statutes (§§316.646, 320.02, 321.245, 324.022, 627.7275, 627.7295); creates a new statute (§324.0221); and amends the Florida Motor Vehicle No-Fault Law (Personal Injury Protection) Statute (§§627.730 through 627.7405). Notably, the reenacted Florida Motor Vehicle No-Fault Law will remain codified and designated with the same statutory numbering. Florida's amended/supplemented Motor Vehicle No-Fault Law was signed by the Governor on October 11, 2007, and became effective on January 1, 2008.

The following is a summary of the changes:

(1) F.S. §316.646 requires each person operating a motor vehicle to have in his or her possession proof of property damage liability coverage.

(2) F.S. § 320.02 clarifies the requirements concerning insurance and liability coverage for certain motor vehicles registered in Florida.

(3) F.S. §324.022 has revised provisions requiring the owner or operator of a motor vehicle to maintain property damage liability coverage, specifies the requirements that apply to such a policy, and requires a nonresident owner or registrant of a motor vehicle maintain property damage liability coverage if the motor vehicle is in the state for more than 90 days during the preceding 365 days. There are provisions for an exception - members of the United States Armed Forces on active duty outside the United States, with definitions of terms used in the section.

(4) F.S. §324.0221 is new, and outlines required reporting criteria for Insurers to the Department of Highway Safety and Motor Vehicles and to the named insured or first named insured. Reporting to the department is required for the issuance, renewal, cancellation or non-renewal of policies providing personal injury protection coverage or property damage liability coverage. This section requires reporting a certain notice of cancellation/nonrenewal to the insured or first named insured. This section also encompasses the suspension of the registration and driver's license of an owner or registrant of a motor vehicle with respect to the security* required under §627.733(3).**

*The term security refers to proof of insurance or self-insurance/financial responsibility evidencing the ability to respond to claims for damages from liability on account of accidents arising out of the use of a motor vehicle. The minimums are $10,000.00 for property damage in a single crash or $30,000.00 combined property damage/bodily injury limit.

**The requirements contained in the new §324.0221 were deleted from former §627.733(6) & (7) and §627.736(9)(a), with the subsequent sections being renumbered to reflect that deletion.

(5) F.S. §627.733(6) & (7) regarding the suspension of the registration and driver's license of an owner or registrant of a motor vehicle with respect to the security required under §627.733(3) has been deleted. That information is now contained in F.S. §324.0221.

(6) F.S. §627.736(1)(a) has been supplemented to include provisions regarding reimbursement of only specifically designated medical services and care. The language regarding necessary remedial treatment and services which rely on spiritual means for treatment have been deleted.

(7) F.S. § 627.736(1)(c) has been supplemented to define death benefits as equal to the lesser of $5,000.00 or the remainder of unused personal injury protection benefits.

(8) F.S. §627.736(4)(c) is new, and requires an insurer to reserve $5,000.00 of personal protection benefits for payments to physicians or dentists licensed under the designated statutes who provide emergency services, care or hospital inpatient care. The funds required to be held in reserve may be used only to pay the described claims until 30 days after the date the insurer receives notice of the accident. The statute specifically states that it is not intended to require an insurer to establish a claim reserve.

(9) F.S. §627.736(5)(a)(2) has been added to address the reimbursement percentages of certain, specifically delineated maximum charges. Consequently, F. S. §§627.736(5)(b)(2), (3), (4) and (5) have been deleted.

(10) F.S. §627.736(10) extends the time for payment of a claim and the prescribed penalty from 15 days to 30 days to foreclose an action against the insurer.

(11) F.S. §627.736(11), (15) and (16) are new. Subsection 11, entitled "Failure to Pay Valid Claims: Unfair or Deceptive Practice, authorizes the penalties provided in section 626.9521. Subsection 15 specifies that all claims related to the same health care provider for the same injured person shall be brought in one action, unless good cause is shown why they should be bought separately. Subsection 15 also permits the denial of an award of attorney fees to a claimant if a claim could have been brought in a prior civil action. Subsection 16 approves of electronic transmission of communications after a mutually expressed agreement between the parties.

While all of the changes identified above are noteworthy, F.S. §627.736(4)(c) is new and requires some additional comment. As stated above, this section requires an insurer to reserve $5,000.00 of personal protection benefits for payments to physicians or dentists licensed under the designated statutes who provide emergency services, care or hospital inpatient care. This section is intended to address the concern of hospitals and emergency physicians that personal injury protection benefits may be exhausted by non-emergency caregivers before they submit their bills for services. In practice, by the time the emergency care provider sends their bill, the insured often has exhausted the available PIP benefits for chiropractic care.

All insurers should comply with this new requirement to reserve $5,000 for the first 30 days after the date the insurer receives notice of the loss, less any emergency care bills which have been received and/or paid. Keeping in mind our obligation to adjust a claim in good faith, we also suggest contacting the insured for confirmation about any emergency care upon receipt of any chiropractic or other non emergency treatment bills within the first thirty days after notice of the claim. Still, to comply with the new law, even if the insured confirms he did not seek emergency treatment, the "reserve" funds should not be released until the expiration of the thirty day period. We also recommend educating the insured about the requirement to retain the $5,000.00

for the thirty (30) day period and the availability of the funds after the retention period has passed.***

> ***Note that the payment periods are tolled for the bills submitted which could have been paid, but did not qualify for payment, with the reserved monies.

As an additional note, until new forms are authorized, an Insurer shall continue to use the Personal Injury Protection forms in effect on September 30, 2007.

Also, the original Personal Injury Protection minimum limits were not changed. Minimum limits remain $10,000.00 for a loss sustained as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle. As indicated above, the death benefit now is the lesser of $5,000.00 or the remainder of unused personal injury protection benefits.

We hope this information will assist you with the significant changes provided in the new Florida Motor Vehicle No-Fault Law. We remain available to discuss any of the above in greater detail. Also, for a more detailed review of the bill, you can log onto the Florida Senate's website, flsenate.gov. On the website, go to the "Bill" box and enter "2007C" at the "Session" prompt. At the "Bill" prompt, enter "40C" and hit "GO". On the next screen, scroll down to the 10/05/07 entry and click on "2007-324". The document is coded for deletions from and additions to the former statute.

CASE NOTES

Georgia Liability

LANDLORD LIABILITY: Under O.C.G.A. § 44-7-14, an out-of-possession landlord is not liable to third persons for damages in tort unless it is shown that the damages resulted either from failure to repair the premises or faulty construction of the premises.

Gainey v. Smacky's Investments, Inc., 287 Ga. App. 529, 652 S.E.2d 167, decided September 12, 2007.

Frank Briggett ("Briggett") and Smacky's Investments, Inc. ("Smacky's") purchased a rental home for investment purposes in 2002. During a pre-purchase inspection, Briggett entered the attic of the home using the two-piece, pull-down staircase. The top portion of the staircase was bolted to plywood that dropped from the ceiling, and a separate portion manually attached to grooves at the bottom of the upper section.

In August 2003, the rental home was rented to Felicia Patterson. At the time of rental, Briggett showed Patterson how to use the attic staircase by assembling it while she watched. Thereafter, Patterson used the attic staircase to place items in the attic without a problem or complaint.

On October 19, 2003, Betty Gainey, Patterson's mother, visited the rental home and asked to store several lamps in the attic. With her daughter's approval, Gainey assembled the staircase and climbed to the top. On her way down, however, Gainey fell, allegedly because the lower portion of the staircase disconnected from the top portion.

Gainey sued Frank Briggett and Smacky's, alleging that they failed to keep the pull-down staircase in proper repair and failed to warn of the dangers it presented. The trial court ruled in favor of both Briggett and Smacky's.

On appeal, the Georgia Court of Appeals found that the trial court's decision was correct. The Court of Appeals determined there was no evidence that Smacky's owned, leased or managed the rental home.

Next, the Court of Appeals determined that Briggett was an out-of-possession landlord under O.C.G.A. § 44-7-14. Under that standard, to recover against Briggett, Gainey must show that Briggett failed to repair the premises or that there was faulty construction and that Briggett failed to warn her of the danger.

The Court of Appeals held there was no evidence that Briggett replaced or repaired the staircase prior to Gainey's fall, and that he was ever notified of any problems with the staircase prior to her fall.

Further, the evidence showed that Briggett did not build or construct the pull-down staircase, because it was already in the house when he bought it. Further, there was no evidence that he had knowledge of any hazards or defects associated with the staircase. Because Briggett did not have superior knowledge of any alleged hazard or defect regarding the staircase, under O.C.G.A. § 44-7-14, he was not liable to Gainey for her claims.

PRODUCTS LIABILITY/EVIDENCE/SUMMARY JUDGMENT: In order to establish a negligent manufacturing claim, a plaintiff must present evidence that the product was defective when it left the manufacturer, due to manufacturer's negligence.

Miller v. Ford Motor Co., 287 Ga. App. 642, 653 S.E.2d 82, decided September 25, 2007.

Dean and Sue Miller sued Ford Motor Company following a motor vehicle accident, alleging that Ford negligently manufactured and assembled the seat belt and side air bag on the front passenger side of their Lincoln Town Car and also failed to warn them of these defects.

The evidence showed that the Millers purchased the used 1999 Lincoln with approximately 31,000 miles in August of 2001. On the morning of May 17, 2002, as Mr. Miller attempted to turn left at an intersection, he collided with another vehicle entering the intersection. Both front air bags on the Millers' vehicle deployed. According to the Millers; however, Mrs. Miller's seat belt did not lock and the side air bag located at the passenger door did not deploy, causing extensive injury to Mrs. Miller as she was thrown against the windshield due to the impact. At the time of the collision, the vehicle had approximately 50,000 miles.

After the close of discovery, Ford moved for summary judgment on the basis of a lack of evidence of a manufacturing defect. The Millers responded to Ford's motion with affidavits stating that Mrs. Miller's seat belt did not lock and her side air bag did not deploy at the time of impact, and that they had made no alterations to the vehicle. The Millers also presented evidence of two product recalls issued by Ford which they alleged pertained to the passenger side seat belt assembly. The trial court granted Ford's motion and the Millers appealed.

The Court of Appeals affirmed, holding that, in order to establish their negligent manufacturing claim, the plaintiffs had to come forward with evidence that, among other things, there was a defect in the car when it left Ford that was caused by Ford's negligence.

The Court held that the Millers had failed to come forward with evidence sufficient to show that there was an original manufacturing defect in the seat belt and side air bag at the time their vehicle left Ford. They offered no evidence of the used vehicle's condition prior to their purchase in 2001, including any prior repairs, accidents, or alterations. They also did not present any expert testimony in support of their assertions. Instead, the Millers relied on their own allegations that the seat belt did not lock and the side air bag did not deploy at the time of the collision, approximately three years after its manufacture and after the vehicle had been driven approximately 50,000 miles. The Court of Appeals held that the affidavits were insufficient because "the mere failure of automobile equipment is not 'itself evidence of an original defect,' since the failure can be the result of myriad causes not related to its manufacture."

With respect to the two product recalls, the Court held those, too, were insufficient to establish a claim since, although a product recall can serve as circumstantial evidence of an original defect, this is only true when it is presented in conjunction with independent proof of a defect in the product in question. In this case, the product recall documents specifically applied not to a defect in the *original* safety belt assembly, but only to vehicles that previously had the "front safety belt retractor replaced *in service*." Because the Millers never presented any evidence that the front safety belt retractor on their vehicle had been replaced while in service, they could not show that the product recalls applied to their vehicle.

The Millers also relied upon the doctrine of *res ipsa loquitur*, which permits the plaintiff in certain cases to prevail even without any specific evidence of negligence where the thing causing injury was in the exclusive control of the defendant and the injury-causing event is of the sort that would not normally occur in the absence of any negligence. The Court rejected that argument on the ground that the doctrine "does not apply to mechanical devices because they get out of working order, and sometimes become dangerous and cause injury without negligence on the part of anyone." The Court held that *res ipsa loquitur* was also inapplicable because Ford clearly did not have exclusive control over the Millers' vehicle. Finally, the Court rejected the Millers' failure to warn claim because that claim was predicated on the existence of a manufacturing defect in the first place.

EVIDENCE/JURY CHARGES: It is harmful error to give a jury charge that does not include or embrace a correct and complete principle of law which is pertinent and adjusted to the evidence.

King v. Davis, 287 Ga. App. 715, 652 S.E.2d 585, decided October 1, 2007.

Nita and Damond King brought a personal injury action against Olin Davis to recover for damages allegedly incurred as result of an automobile collision. At trial, the court admitted evidence of the Kings' failure to wear their seatbelts at the time of the collision. At the conclusion of trial, the court instructed the jury "when considering damages, you may take into account evidence of [the Kings'] alleged failure to use an available seatbelt upon proof or showing by [Davis] satisfactory to you that [the Kings] did not use their seatbelt and that their injuries may have been reduced by use of a seatbelt." The Kings appealed the jury verdict on the grounds the trial court erred in giving the above charge. The Kings also appealed the admission of their testimony that they were not wearing a seatbelt at the time of the collision.

The Kings argued on appeal that the trial court should not have given the jury charge because it was a misstatement of law. O.C.G.A. § 40-8-76.1(d) provides: "The failure of an occupant of a motor vehicle to wear a safety belt in any seat of a motor vehicle which has a seat safety belt or belts shall not be considered evidence of negligence or causation, shall not otherwise be considered by the finder of fact on any question of liability of any person, corporation, or insurer, shall not be any basis for cancellation of coverage or increase in insurance rates, and shall not be evidence used to diminish any recovery for damages arising out of the ownership, maintenance, occupancy, or operation of a motor vehicle." The Court noted the General Assembly's purpose in enacting the statute was to ensure the failure to use a seatbelt was not introduced in evidence in any civil action. The General Assembly wanted to prevent those who caused a motor vehicle collision from escaping liability by raising the defense that the injured party was not wearing a seatbelt.

The Court of Appeals did not consider the Kings' appeal on the admission of their testimony concerning the wearing of the seatbelt because it was not timely objected to at trial.

A jury charge must be adjusted to the evidence and a correct statement of applicable law. Harmful error will result when an inapplicable charge is given and might reasonably draw the jury away from the true issues in dispute. Harmful error will also result if the erroneous charge is inapplicable to a vital issue in the case. Because the jury charge in the case was not in accordance with O.C.G.A. § 40-8-76.1(d), and it likely prejudiced the Kings' case, the Court of Appeals reversed and ordered a new trial.

PREMISES LIABILITY/SUPERIOR KNOWLEDGE: Homeowner not liable to painter for injuries suffered when painter came into contact with frayed electrical wires running from utility pole to home where homeowner's knowledge of the condition was not superior to that of the painter.

Schuessler v. Bennett, 287 Ga. App. 880, 652 S.E.2d 884, decided October 19, 2007.

Johnny Bennett ("Bennett") was painting the exterior of Kim Schuessler's ("Schuessler") house when electricity arced from a power line to the ladder on which he was standing. Bennett fell off the ladder and sustained significant, permanent physical injuries. Bennett filed suit against Schuessler alleging she was negligent in failing to inspect and maintain her property. Bennett also sued the City of Jackson, its Mayor, members of the City Council, and the Jackson Electric Department ("City Defendants") for the same claims. Schuessler and the City Defendants moved separately for summary judgment. The trial court denied the motions, and all defendants appealed.

During his deposition, Bennett testified that before beginning to paint Schuessler's house he noticed the wires were frayed and uninsulated in spots. His boss also told him the wires were frayed and to be careful. Bennett's co-worker testified that he and Bennett had discussed how to best work around the power

lines before they started painting. Schuessler, on the other hand, had merely asked Bennett "to be careful" when working around the wires.

The City Defendant's expert witness testified during his deposition that the National Electric Safety Code stated that wiring should be inspected "at such intervals as experience has shown to be necessary," but did not specify or require a specific inspection schedule. The expert opined further that there was no requirement that the power wires had to be insulated in the first place because they were attached to Schuessler's house at a point greater than 12.5 feet from the ground.

As Bennett was an independent contractor at the time of the incident, he was responsible for determining whether his place of employment was safe. In Georgia, a landowner is not an insurer of an invitee's safety; the invitee must exercise ordinary care for his own safety and must avoid the effect of the landowner's negligence when such negligence becomes apparent to him or he should have learned of it in the exercise of ordinary care. "The ground for an owner's liability is his or her superior knowledge of the danger of defect."

Though Schuessler had cautioned Bennett "to be careful" when working around the wires in general, Bennett offered no evidence to show that Schuessler's knowledge of the danger of electrical arcing posed by the frayed and uninsulated wire was superior. Bennett's deposition testimony established that his boss had warned him about the condition of the wire, and that he and his co-worker had talked about working around the wires prior to starting the job. As such, "[t]he record unequivocally belies any assertion that [Schuessler] had greater understanding than [Bennett] regarding the potential hazards of the task undertaken." The Court of Appeals held that the trial court erred in denying Schuessler's motion for summary judgment.

The City Defendants, however, did not fare so well on appeal. Georgia law holds that "[a] power company is charged with the duty of exercising ordinary care in the construction and maintenance of its wires, poles, transformers and equipment," and the City Defendants' own expert also testified that electrical utilities have a duty to conduct periodic inspections. The City Defendants were unable to produce any evidence that the wires in question had ever been inspected, which resulted in a question of fact as to whether the City Defendants had failed to exercise ordinary care in inspecting and maintaining the service line to Schuessler's home.

Finally, the evidence did not demand a finding that Bennett had assumed the risk of injury, as offered by the City Defendants as a defense. To succeed on a defense of assumption of the risk, a defendant must show a plaintiff had (1) actual knowledge of the danger; (2) understood and appreciated the risk; and (3) voluntarily exposed himself to the risk. Here, the conversations about the general condition of the wires did not allow for an assumption to be reached that Bennett understood there was a risk of electricity arcing from the frayed and uninsulated wires to his ladder. As such, the City Defendants failed to show Bennett had superior knowledge of the risk involved, and the Court of Appeals upheld the trial court's denial of the City Defendants' motion.

INSURANCE COVERAGE/DUTY TO DEFEND: A policy exclusion must unambiguously exclude a plaintiff's allegations from coverage for a carrier to be absolved of the duty to defend its insured.

Fireman's Fund Ins. Co. v. University of Georgia Athletic Association, Inc., 2007 WL 3345094 (Ga. App.), decided November 9, 2007.

In the fall of 2003, the University of Georgia Athletic Association, Inc. ("Association") hired Wilder to coordinate the Association's student athlete disability program. Wilder was responsible for explaining the insurance program, requesting quotes for eligible student athletes and transmitting coverage request forms to insurance brokers.

On October 21, 2003, junior football athlete Decory Bryant told Wilder he wanted a disability policy. On October 23, 2003, Wilder solicited quotes from several brokers but failed

to obtain a coverage request form from Decory Bryant ("Bryant"). On October 25, 2003, Bryant suffered a severe spinal injury ending any type of career in football. It was not until October 29, 2003, that the Association presented Bryant with a coverage request form; however, the disability carrier refused to back-date coverage to October 23, 2003 without proof that Bryant had reviewed the quotes and signed a coverage request form prior to the injury.

On December 17, 2004, Bryant sued Wilder and the Association for breach of fiduciary duties, breach of contract and negligence. He claimed damages as the amount of coverage that should have been available as disability coverage, punitive damages and attorney's fees. The Association notified its general liability carrier, Fireman's Fund, and requested a defense and indemnification. Fireman's Fund refused to provide a defense and filed a Complaint for Declaratory Judgment claiming it had no duty to defend or indemnify because the incident occurred outside of the policy period and was excluded as: "arising out of, in consequence of or in any way related to the Insured's failure to effect or maintain insurance," and "arising out of, in consequence of or in any way related to any Bodily Injury...".

An insurance carrier's duty to defend is resolved by comparing the allegations of the complaint to the terms of the insurance policy. A policy imposes a duty to defend even where the allegations are false, fraudulent and groundless if the allegations fall within the policy coverage. Where the allegations are ambiguous or incomplete as to coverage, the insurer is obligated to defend.

The Association claimed that the failure to effect or maintain insurance exclusion was ambiguous because the policy did not distinguish between the types of insurance that applied to the exclusion. The Georgia Court of Appeals noted that this exclusion is typically found in D & O policies and is designed to exclude the conduct of procuring insurance because the act would typically be covered by a separate commercial general liability policy. The Court of Appeals held that because there was no other insurance available to the Association to cover this type of incident, the exclusion can be narrowly read to except this type of claim from the exclusion. Therefore, the exclusion was ambiguous; and, when construed in favor of the Association, might not exclude Bryant's allegations from coverage.

The Court of Appeals also addressed the bodily injury exclusion. The Court reasoned that there was no causal nexus between Bryant's bodily injuries and any act or omission of the Association. Therefore, the relationship between the insured and the bodily injury was too tenuous and the incident did not fall within the ambit of the exclusion.

The Court of Appeals ultimately held that Fireman's Fund owed a duty to defend both the Association and Wilder because the exclusions asserted by Fireman's Fund did not unambiguously exclude coverage for Bryant's allegations. The Court of Appeals did not address the policy period issue in its opinion. The Court of Appeals also did not rule on the indemnification issue as it claimed there was insufficient information in the record to decide Fireman's Fund's duty to pay, an issue separate and distinct from the duty to defend.

PREMISES LIABILITY/CONSTRUCTIVE NOTICE OF HAZARDOUS CONDITION: Summary judgment is improper when a genuine issue of material fact exists as to whether property owner's inspection procedure was reasonable.

Gibson v. Halpern Enterprises, 2007 WL 3379827 (Ga. App.), decided November 15, 2007.

Hazel Gibson ("Gibson") slipped and fell on gravel in a shopping center parking lot outside of her workplace. Gibson filed suit against the owner of the shopping center, Halpern Enterprises ("Halpern"). The trial court granted Halpern's motion for summary judgment finding no evidence that Halpern had actual or constructive knowledge of the hazard. Gibson appealed.

The Court of Appeals found that as an employee of one of Halpern's tenants, Gibson was an invitee on the property. As such, Halpern may be liable for injuries caused by its failure to exercise ordinary care in keeping the premises and approaches safe. To recover for injuries sustained in a slip-and-fall action, an invitee must prove (1) that the defendant had actual or constructive knowledge of the hazard; and (2)

that the plaintiff lacked knowledge of the hazard despite the exercise of ordinary care due to actions or conditions within the control of the owner/occupier.

Halpern sought summary judgment arguing Gibson could not establish that Halpern had actual or constructive knowledge of the gravel. Constructive knowledge may be shown by showing that an employee of the defendant was in the immediate vicinity of the fall and had an opportunity to correct the hazardous condition before the fall *or* by showing that the substance had been present for a sufficient length of time that it would have been discovered and removed had the proprietor exercised reasonable care in inspecting the premises.

Gibson argued that Halpern had constructive knowledge of the gravel because it did not have in place a reasonable procedure for inspecting the parking lot, including the area near the dumpster, to make sure that it was free of hazardous conditions.

Constructive knowledge may be inferred when there is evidence that the owner lacked a reasonable inspection procedure. The owner must show not only that it had a reasonable inspection program in place, but that such program was actually carried out at the time of the incident. Halpern presented evidence that it had arranged for a cleaning company to sweep the parking lot, including the dumpster area, every day. Halpern's property manager testified that he visited the property at least once a week and checked the work done by the cleaning company, which was always satisfactory.

However, Gibson argued that Halpern was liable for her fall because it failed to inspect the property on the day of her fall. The Court found that whether the inspection occurred on that specific day was irrelevant, unless a reasonable inspection procedure would have required a daily inspection. The specific facts and circumstances of a case determine the reasonability of an inspection procedure.

The Court found that the trial court's order granting summary judgment should be reversed because a jury question existed as to the reasonableness of Halpern's inspection procedure.

Florida Liability

PRESUMPTION OF NEGLIGENCE BY REAR VEHICLE DRIVER IN A REAR-END COLLISION: Evidence at trial that fairly and reasonably rebuts the presumption of negligence requires the issue of defendant's negligence be presented to the jury for determination without the aid of the presumption.

Marcellus v. Cronan, 963 So.2d 364 Fla. App. 4 Dist., 2007, decided August 29, 2007.

Plaintiff Marcellus filed a Complaint asserting Mr. Cronan was negligent for rear-ending a vehicle in which Mr. Marcellus was a passenger. During the trial, Mr. Marcellus' attorney requested a jury instruction regarding the presumption of negligence of a driver in a following vehicle involved in a "rear-end" automobile accident. The trial court declined to give that instruction finding that sufficient testimony had been presented to the jury to support a factual finding that the vehicle in which Mr. Marcellus was a passenger may have been improperly parked or stopped on the shoulder of a roadway at the time of the accident, and not properly positioned waiting for traffic to move forward.

In Florida, there is a rebuttable presumption of negligence which attaches to the driver of a rear vehicle in a rear-end collision. The Fourth District Court of Appeal held that this presumption of negligence may be rebutted if the defendant driver, the driver of the following vehicle, presents evidence which fairly

and reasonably tends to show that the real facts are not as presumed. Here, the Court of Appeal found that Defendant Cronan had presented sufficient evidence to the jury that fairly and reasonably tended to show that Mr. Cronan was not negligent, thereby rebutting the presumption of negligence that would normally arise in a standard rear-end collision case.

ADDITUR: When there is undisputed evidence supporting an award of damages and the jury fails to make such an award, it is error for the trial court to deny a motion for additur.

Garrett v. Miami Transfer Co., Inc., 964 So.2d 286, 32 Fla. L. Weekly D2302, decided September 26, 2007.

In this case, Plaintiff Michael Garrett was hired by Florida Power and Light to decommission a transformer on Florida Power and Light's property. The transformers generally are scrapped in the field because of their massive size, some units weighing nearly 800,000 pounds.

While working to decommission one of the transformers, Michael Garrett was ordered to climb on top of a certain transformer, which tipped slightly causing Mr. Garrett to fall approximately 13 feet to the ground. At trial, the evidence was undisputed regarding the extent of Mr. Garrett's injuries and disabilities. Experts for both Plaintiff and Defendant essentially agreed on damages.

After a trial, the court entered a judgment finding the utility negligent and the worker comparatively negligent. Plaintiff was awarded damages for past and future medical expenses, for past lost earnings ability, for past pain and suffering, but nothing for future loss or incapacity and future pain and suffering. The court then denied Mr. Garrett's motion for additur or for a new trial on damages. Mr. Garrett appealed.

The Fourth District Court of Appeal held that the trial court erred in failing to grant an additur. The Court found that the amount awarded did not bear a reasonable relation to the amount of damages proved and the injuries suffered by Plaintiff. This finding was based upon the facts that the jury awarded future medical expenses and heard undisputed evidence that Plaintiff would continue to suffer as a result of those injuries, but still failed to award future pain and suffering damages.

Notably, however, where evidence is conflicting and the jury could have reached its verdict in a manner consistent with that evidence, it would be error for the trial court to veto the jury verdict by granting a motion for additur.

POLICY EXCLUSION: When an insurer relies on an exclusion to deny coverage, the insurer has the burden of demonstrating that the allegations of the complaint are cast solely and entirely within that policy exclusion and are subject to no other reasonable interpretation.

Castillo v. StateFarm Florida Ins. Co., ---So.2d---, 2007 WL 3005974 (Fla. App. 3 Dist.), 32 Fla. L. Weekly D2474, decided October 17, 2007.

The Castillo's filed suit against State Farm for breach of contract due to the denial of an insurance claim for damages to their home. In their Complaint, the Castillo's alleged that nearby blasting created shock waves and vibrations which damaged the insured's dwelling without the displacement or permanent displacement of earth.

State Farm denied Plaintiffs' contentions arguing that its policy specifically excluded damages for earth movement. Relying on a prior Third District Court of Appeal's holding, which looked at an earth movement exclusion as resulting from both natural and man-made events, the trial court granted State Farm's Motion for Summary Judgment. In the prior decision, the Third District Court of Appeal explained that the exclusionary clause identified had a lead in provision which set forth that the insured did not insure for loss regardless of the cause of the excluded event.

The Court of Appeal distinguished the instant case from the above mentioned previous case. Unlike in the prior case, the Castillo's claimed that the vibrations and shock waves caused by the blasting did not result in displacement of earth. Moreover, the policy at issue did not specifically address whether the damages caused by blasting shock waves or vibrations categorically fell under earth movement and be excluded from coverage. The Court concluded that the allegations raised by the Castillo's, if true, may fall outside the earth movement exclusion and remanded the case. Specificity is crucial in giving affect to and construing an exclusion.

FLORIDA'S IMPACT RULE: Being touched against your will and without physical injury is sufficient to satisfy the Florida Impact Rule.

Willis v. Gami Golden Glades, LLC, 967 So.2d 846, 32 Fla. L. Weekly S643, decided October 18, 2007.

Plaintiff Willis wanted to park in front of the Holiday Inn where she was going to stay. However, because no parking spaces were available, a security guard specifically instructed her to park in the parking lot across the street. Plaintiff Willis expressed some concern about the lot, but the guard assured her that it was safe to park there.

When Plaintiff exited her vehicle at the lot across the street from the hotel, a gunman placed a gun against her head. The gunman ordered that she empty her pockets, took her purse, and patted her down to see if she was hiding any other money or valuables.

After the gunman had stolen her rental car and driven off, the security guard refused to provide assistance and acted as if he had never seen her. Moreover, Ms. Willis did not receive any aid from the hotel personnel inside the facility. Subsequently, Ms. Willis suffered sleepless nights during her stay.

Ms. Willis sued the owner of the hotel. The trial court granted Defendant Holiday Inn's Motion for Summary Judgment, holding that Florida's Impact Rule precluded the plaintiff from recovering for severe psychological damage as a result of the negligence of the defendant's failure to exercise reasonable care to protect her from a foreseeable criminal action.

The Florida Supreme Court reversed finding that as a guest at the hotel, Plaintiff Willis contracted for security services with American Security. The Court was persuaded by the facts that Plaintiff Willis was specifically instructed to park her vehicle in the parking lot across the street and assured it was safe, but, then, refused any assistance.

Addressing Florida's Impact Rule, the Court found that Ms. Willis did suffer an impact when the gun was placed against her head and when she was subsequently patted down by the assailant who was looking for valuables. The Court held that this contact was sufficient to qualify as an impact under Florida's Impact Rule. Reiterating previous holdings, the Court stated that the impact is sufficient so long as it is from an outside force or substance, no matter how large or small, visible or invisible, even if the effects are not immediately deleterious, so long as the impact touched or entered into the plaintiff's body.

In Florida, there are prerequisites for recovery for negligent infliction of emotional distress, which differ, depending whether the plaintiff has or has not suffered physical impact from an external force. If there is an impact, Florida courts permit recovery for emotional distress stemming from the incident during which the impact occurred.

However, if the plaintiff did not suffer an impact, the mental stress complained of must be manifested by a physical injury and the plaintiff must be involved in the incident by seeing, hearing, or arriving on the scene as the traumatizing event occurs. Additionally, the plaintiff must suffer the complained of mental distress and accompanying physical impairment within a short time of the incident.

POLICY AMBIGUITY: The policy language "any other person with respect to liability because of acts or omissions of a named insured" is unambiguous and limits an additional insured's coverage to instances of vicarious liability.

Garcia v. Federal Ins. Co., ---So.2d---, 2007 WL 3101820 (Fla.), 32 Fla. L. Weekly S657, decided October 25, 2007.

Ms. Garcia was working as a caregiver for the insured Laura Anderson. Her duties included running errands, for which she used an automobile owned by Anderson's son-in-law, Mr. Veith. During an errand to the supermarket, Ms. Garcia's foot slipped off the brake peddle causing her to strike and seriously injure a pedestrian.

The injured person sued Mr. Veith, Ms. Anderson and Ms. Garcia. The complaint alleged Veith, Anderson and Garcia were each independently negligent for allowing the brake peddle to wear down to the point that bare metal was all that remained, thereby causing Ms. Garcia's foot to slip off the peddle.

At the time of the accident, Ms. Anderson was covered by a Federal Homeowners Insurance policy. Federal subsequently settled the claims against Anderson.

After settling with the injured pedestrian, Ms. Garcia sought coverage from Federal as an additional insured with respect to liability due to the acts or omissions of Anderson. Federal denied the claim on the grounds the policy's additional insured clause only covers individuals who become vicariously liable for the acts or omissions of a named insured. In this case, Ms. Garcia was sued for her own negligent acts not for any acts or omissions of Anderson.

Ms. Garcia appealed. The District Court held that Ms. Garcia would only be entitled to coverage under a theory of vicarious liability stating that a plain reading of "with respect to liability because of acts or omissions of "you"" means, in this case. that Garcia is covered under policy if Garcia could be liable for striking a pedestrian because of Anderson's failure to maintain the brake peddle. However, because the victim sued Garcia for her own negligence, the court held that Ms. Garcia was not a covered person under the policy.

The Florida Supreme Court held that Florida law calls for contract construction according to the plain meaning. If the relevant policy language is susceptible to more than one reasonable interpretation, one providing coverage and another limiting coverage, then the language is considered ambiguous. An ambiguity in an insurance contract is interpreted against the insurer and in favor of the insured.

Based on the foregoing, the Court found that the phrase "any other person with respect to liability because of acts or omissions" of the named insured was not ambiguous and covered only an additional insured's vicarious liability for the negligent acts or omissions of the named insured. The Court went on to state that a provision is not ambiguous simply because it is complex or requires an analysis.

Therefore, Federal's policy does not cover the additional insured's independent acts of negligence. Consequently, because the accident victim sued against Garcia, sought recovery only for her direct negligence, and did not allege liability based on acts or omissions of Anderson, Garcia is not entitled to coverage.

Georgia Workers' Compensation

EMPLOYER MUST PROVE FULL AND COMPLETE COMPENSATION TO ENFORCE LIEN: An employer must prove that a claimant was fully and completely compensated by a third-party tortfeasor before the employer is able to enforce a subrogation lien, and lump sum settlement documents, alone, are insufficient evidence to satisfy the full and complete compensation requirement.

Paschall Truck Lines, Inc. v. Kirkland, 287 Ga. App. 497, decided September 11, 2007.

Claimant, a commercial truck driver for Employer, was injured in a motor vehicle accident in Georgia with another commercial truck driver. Employer's main office was in Kentucky, where Claimant subsequently filed his workers' compensation claim. Claimant received medical and indemnity benefits pursuant to Kentucky's workers' compensation laws.

Claimant also filed a workers' compensation claim in Georgia. After settling his Georgia workers' compensation claim, Claimant initiated a civil lawsuit against the other driver and the other driver's employer.

Claimant's Employer filed a motion to intervene in the civil lawsuit to assert its subrogation lien pursuant to O.C.G.A. § 34-9-11.1 for reimbursement of the workers' compensation benefits paid. Claimant subsequently settled his civil lawsuit. In response to Employer's motion, Claimant filed a motion to extinguish Employer's subrogation lien.

The trial court held that since no benefits were paid under the Georgia Workers' Compensation Act, Employer had no right to subrogation. The trial court based its decision, at least in part, on the language within the settlement agreement.

The trial court additionally decided in favor of Claimant based on O.C.G.A. § 34-9-11.1(b), which requires a claimant to be fully and completely compensated for all economic and non-economic losses before the employer can recover on its subrogation lien. Claimant presented evidence showing he was not fully and completely compensated for his injury. Employer, who bears the burden of proof, presented no evidence to the contrary.

The Court of Appeals explained that once a claimant settles with a tortfeasor for a lump sum, a reviewing court cannot determine the proportion of economic compensation versus noneconomic compensation based on the language in the documents. Therefore, the court had insufficient evidence to determine whether Claimant was fully and completely compensated for his injury. The Court held that Employer failed to carry its burden of showing that Claimant was fully and completely compensated within the meaning of O.C.G.A. § 34-9-11.1(b).

APPELLATE REVIEW/ PROCEDURE ON REMAND: Reviewing court may not remand controversy directly to ALJ, bypassing State Board and effectively vacating previous Board holding.

YKK (USA), Inc. v. Patterson, 652 S.E.2d 187, decided Sept. 13, 2007.

On November 6, 2003, Kimberly Patterson went to the emergency room after noticing that her right lower leg was blotchy, red, and swollen. Although she initially told co-workers and her treating physicians that she did not know why her leg swelled and that she had not been injured, she later alleged that she tore a muscle while pushing a tool cart at work.

In support of her workers' compensation claim, Patterson relied upon the depositions and narrative reports of several physicians. However, none of the doctors who treated her from the day she allegedly tore her leg muscle through the following eleven months diagnosed her with a work related injury or determined the cause of her condition. Ultimately, only one doctor, who began treating her almost a full year after she suffered her alleged injury, concluded that work-related activity caused her injury. Consequently, an Administrative Law Judge ("ALJ") denied Patterson's claim for benefits, finding that she did not show by a preponderance of the evidence that she sustained an injury arising out of and in the course of her employment.

After the Full Board affirmed the ALJ's decision, Patterson appealed to the Superior Court of Bibb County, which concluded that the ALJ improperly overlooked certain evidence pertaining to the time at which Patterson first reported pain. However, rather than recommitting the controversy to the Full Board, the Superior Court remanded to the ALJ for further consideration of that evidence.

On appeal, YKK successfully argued that such a procedure is improper. The Georgia Court of Appeals held that a superior court is not authorized to remand a case directly to the ALJ who rendered the original award. YKK further contended that the Superior Court in this case acted outside the scope of its authority by effectively vacating the Board's award when it remanded to the ALJ. YKK argued that because the Board's Award was supported by some evidence, the "any evidence" standard of review required the Superior Court to affirm the Full Board's decision. Agreeing with YKK, the Court of Appeals reiterated that the Board, not a reviewing court, must determine the weight and credibility to be given to witness testimony, including the opinion testimony of physician witnesses, and to resolve issues of fact arising from conflicts in the evidence.

Given that the Board generally adopted the ALJ's findings, and that the ALJ weighed the physicians' testimony to determine Patterson's injury was not caused by work-related activity, the Superior Court acted improperly in subverting the Board's conclusion that Patterson did not suffer a work-related injury. Therefore, the Court of Appeals upheld the Full Board's Award.

EFFECT OF RECEIPT OF WORKERS' COMPENSATION BENEFITS ON RECOVERY IN THIRD-PARTY SUIT: An award to a plaintiff in a personal injury suit generally cannot be offset by workers' compensation or similar benefits paid to the plaintiff/insured.

Dees et al v. Logan, 2007 WL 4124536 (Ga. Supreme Court), decided November 21, 2007.

Plaintiff Dees filed suit against Defendant Logan for injuries he sustained in a motor vehicle accident. Dees succeeded at trial and was awarded lost wages, reimbursement of medical expenses, and compensation for pain and suffering and loss of consortium. Dees already had received workers' compensation benefits and social security disability benefits as a result of the accident, as well. Dees also had been paid $25,000 by Logan's liability insurer.

Following the award, Dees' uninsured motorist (UM) carrier, State Farm, attempted to reduce the amount of the award by the amounts paid to Dees in workers' compensation benefits, Social Security Disability benefits and a pre-trial settlement with Logan's liability insurance carrier. State Farm argued that the provisions of the UM policy expressly stated that "any amount payable ... shall be reduced by any amount paid or payable to or for the insured: (a) under any workers' compensation, disability benefits or similar law."

Both the trial court and the Court of Appeals agreed with State Farm. As a result, Dees did not see any of the award rendered in his favor by the jury, and therefore appealed.

The Supreme Court reversed the lower courts. In doing so, the Court noted that the plain language of Georgia's UM statute (O.C.G.A. §33-7-11) authorized an uninsured motorist carrier to setoff benefits which its insured may have received to compensate for *property* loss. That Section did not provide for a similar procedure involving personal or bodily injury. Therefore, the Court found that the legislature

specifically intended to only allow a setoff for loss to property. The Court rejected State Farm's argument that by allowing Dees to keep his recovery in the personal injury action and his other benefits he would in effect have a "double recovery." The Court rejected that theory by stating that State Farm only had to pay once, for their liability, as were the other parties or payors.

DEFENSE OF CLAIM/AWARD OF ATTORNEYS FEES: Appellate Division's factual finding that employer's unsuccessful defense of claim was nonetheless reasonable is binding on reviewing courts.

L & S Construction v. Lopez, 2007 WL 4150995 (Ga. App.), decided Nov. 26, 2007.

When Martin Lopez filed a workers' compensation claim in early 2004, after suffering a construction-related injury, a dispute arose between Bob St. John Construction and its subcontractor, L & S Construction. St. John contended that L & S employed Lopez at the time of the accident. On the other hand, L & S's owner, Jim Lawhorne, Jr., presented evidence that Lopez was in fact employed by his father, Jim Lawhorne, Sr. Given that the elder Lawhorne did not have workers' compensation coverage, the employment issue would determine whether the contractor's or the subcontractor's insurance would have to compensate Lopez for his injuries.

Post-hearing, an Administrative Law Judge (ALJ) found L & S's defense of the claim unreasonable. Therefore, the ALJ awarded attorney fees to both St. John and Lopez. However, the Appellate Division of the State Board of Workers' Compensation reversed, finding that a reasonable dispute existed on the issue of Lopez's employment. As such, the award of attorney fees was improper. When the Superior Court overturned the Board's holding, L & S again appealed.

In reversing the Superior Court's decision, the Georgia Court of Appeals first considered the standard of review. The Court stated, upon review "we construe the evidence in a light most favorable to the party prevailing before the Appellate Division and will uphold the Division's factual findings if there is any evidence to support them." That is, when the State Board's findings of fact are supported by any evidence at all, those findings are conclusive and binding upon the reviewing courts.

In this case, the Superior Court erred by substituting its own factual conclusions for those of the Board. L & S presented enough evidence to convince the Appellate Division that a reasonable dispute existed as to Lopez's employer. An employer's defense of a claim may be reasonable, noted the Court of Appeals, even if it is not ultimately successful. And when there is some evidence to support such a factual conclusion, the Superior Court is required to affirm the Board's finding.

WORKERS' COMPENSATION CLAIMANTS LACK STANDING TO PURSUE REIMBURSEMENT FOR A MEDICAL PROVIDER: Judge of Compensation Claims does not have jurisdiction over reimbursement disputes between medical providers and carriers for unpaid medical treatment.

The Avalon Center and Unisource Administrators v. Hardaway, 32 Fla. L. Weekly D2274, decided, September 28, 2007.

On December 11, 1991, Claimant, a child therapist at The Avalon Center was attacked by one of her patients. Employer/Carrier accepted the claim as compensable and authorized medical treatment.

In November 1995, Employer/Carrier authorized medical treatment with Dr. Paul Neal, a clinical psychologist, to treat Claimant's depression, post-traumatic stress disorder, and suicidal ideation. Employer/Carrier alleged that Dr. Neal billed the carrier more than $37,000.00 for psychotherapy, and submitted the charges for utilization review pursuant to §440.13(6).

After the utilization review was initiated, Dr. Neal testified he received notice of the review of certain bills for treatment that were disallowed by Carrier. He further testified that he was aware that Claimant was not responsible for payment of the disallowed bills. Dr. Neal was aware that he could challenge the denial by filing a petition with the AHCA. However, instead, he allowed Claimant to pursue a dispute before the JCC.

Claimant filed a petition for benefits on October 24, 2005 seeking reimbursement for the dates of service disallowed by the carrier. Carrier filed a Motion to Dismiss the petition for lack of subject matter jurisdiction, arguing that the Agency for Healthcare Administration (AHCA) had exclusive jurisdiction to resolve reimbursement disputes between an insurance carrier and a healthcare provider. The JCC reserved on this motion until after the final hearing.

On April 28, 2006, the JCC entered the final compensation order stating that a claimant may bring a petition for benefits seeking payment of past medical bills and that it had jurisdiction pursuant to §440.192(2) to resolve petitions for past medical bills. Furthermore, the court reasoned that, while AHCA has jurisdiction over utilization reviews, the only evidence of the claim being subject to utilization review was excluded due to hearsay grounds. Therefore, without evidence of utilization review, the JCC had subject matter jurisdiction to resolve the dispute. Employer/Carrier appealed on the grounds of a lack of jurisdiction and standing.

The First District Court of Appeal held that §440.192(2) did not expressly grant the JCC jurisdiction. Rather, it provided basic procedural requirements for a sufficient petition, in contrast to the JCC's conclusion of law. The First District Court of Appeal relied upon the specific wording within §440.13(11)(c) providing exclusive jurisdiction over reimbursement disputes and utilization review to AHCA.

The Court defined a "reimbursement dispute" as any disagreement between a health care provider or health care facility and carrier concerning payment for medical treatment." §440.13(1)(r). Therefore, the First District Court of Appeal held that the AHCA had exclusive jurisdiction over the medical bill dispute, and the final compensation order was reversed.

Addressing the standing issue, the Court found that §440.13(14) provided that a health care provider may not collect or receive a fee from an injured employee within this state, except as otherwise provided in chapter 440. Such providers have recourse against the employer or carrier for payment of services rendered. Therefore, the Claimant is shielded

from liability in any dispute between the employer/carrier and a health care provider regarding reimbursement for authorized medical treatment. Absent any real financial liability, Claimant was without standing to pursue a reimbursement dispute on Dr. Neal's behalf.

WORKERS' COMPENSATION CLAIMS FOR REPETIVE TRAUMA MAY NOT BE BARRED BY THE STATUE OF LIMITATIONS: The statute of limitation did not bar a claimant's petition for benefits for carpal tunnel syndrome caused by repetitive trauma when the employer was aware that his job duties caused him to suffer new repetitive trauma each time he performed job duties of entering data into a computer.

Troche v. Geico and Rawlings Co., LLC., 32 Fla. L. Weekly D2401, decided October 12, 2007.

Claimant appealed the denial of his workers' compensation claim for bilateral carpal tunnel syndrome. Claimant originally filed a claim on April 12, 2000, but did not request medical or indemnity benefits until the new petition was filed more than two years later. However, the Claimant continued to work the same job of entering data into the computer since filing his original claim for workers' compensation benefits.

The First District Court of Appeal held that in repetitive trauma injury cases, the date of injury is generally deemed to be the last date of exposure to the trauma. In the instant case, the Claimant's filing of a previous workers' compensation claim for the same injury did not change the fact that he continued to suffer a new repetitive trauma each time he performed his job duties of entering data into the computer.

Significantly, the First District Court of Appeal pointed out that the employer did not change his job duties after he filed his claim. The initial notice of injury should have provided sufficient notice to the employer that Claimant's duties were causing the injury. Had the employer taken steps to change Claimant's job functions and eliminate his exposure to the repetitive injury, the statue of limitations would have run from the time Claimant filed his original notice of injury. If the position was changed, then the last date of exposure would have been determined from that date he was last exposed.

However, Claimant continued his job duties, continuing to suffer its harmful results. The prior filing of a claim for the same condition has no effect on when the statute of limitations begins to run in a repetitive trauma injury. The order denying the claim due to the statute of limitations was reversed for the JCC to consider the merits of the petition regarding the wrist injuries.

WORKERS' COMPENSATION SUBROGATION LIENS: Determination of an employer/carrier's lien on net proceeds received by a claimant from the settlement of a tort action against tortfeasor cannot exceed Claimant's net recovery.

Luscomb v. Liberty Mutual Insurance Company & BJ's Wholesale Club Inc., 32 Fla. L. Weekly D2468, decided, October 26, 2007.

Claimant injured his right foot, ultimately requiring amputation, while delivering goods to BJ's Wholesale Club working for Raven Transport Company. Liberty Mutual, insurer for Raven Transport Company provided workers' compensation medical and indemnity benefits totaling $1,120,408.

Claimant filed a third party tort action against BJ's Wholesale and BJCR, Ltd. for his damages from the work-related accident. As a result, Liberty Mutual filed their notice of subrogation lien in the third party action for recovery of workers' compensation benefits paid to Claimant.

Following mediation, Claimant settled his third party action for $215,000. The contingency agreement for the tort action provided that his attorney was entitled to

attorney fees of $86,000 and costs of $47,252. The attorney fees and costs were deducted from Claimant's settlement leaving Claimant a net recovery of $81,748.

Liberty Mutual asserted that they were entitled to a pro rata share of the settlement proceeds before the attorney fees and costs were deducted. The trial court stopped short of requiring Claimant's attorneys to repay that amount to the trust account balance held for the Claimant. The final judgment imposed a lien of $132,410, but limited Claimant's obligation to his net recovery of $81,748.

Claimant appealed asserting that the $215,000 settlement was not the full value of damages sustained for purposes of determining the lien statute. Furthermore, Claimant argued that the trial court should have made the determination of the full value of the tort claim and that the lien should only be subject to the net recovery.

The Court of Appeal held that the controlling factor for evaluating the settlement allocation is the "ratio of net recovery to full value of damages." In addition, the Court held that Claimant's attorney could not be penalized for producing a subrogation recovery for the insurer for successfully prosecuting the worker's claim against a third party tortfeasor and having their attorney fees and costs reduced.

The District Court of Appeal reversed and remanded the case with directions to determine the full value of damages sustained and to apply the appropriate computation for lien determination. The Court specifically provided the formula of taking the net settlement and dividing it by the full value of damages sustained to produce the percentage of recovery. Then, the trail court was instructed take the total benefits paid to Claimant from the workers' compensation claim and multiply it by the net recovery to produce the lien amount.

In the instant case, the net settlement after attorney fees and costs was $81,748. The assumptive full case value was illustrated as 5 million dollars. As a result, the percentage of net recovery was 1.635 percent. The next step required taking the total amount paid by Liberty Mutual of $1,120,408 and multiplying it by the .01635 percentage of net recovery for the lien amount of $18,318.

WORKERS' COMPENSATION ATTORNEYS' FEES: The Judge of Compensation Claims has jurisdiction to construe a settlement agreement for the payment of pre-settlement Medicare bills submitted after the settlement agreement was reached to determine attorney fees.

Mccallum v. Palm Beach County School District, 32 Fl. L. Weekly D 2840, decided December 7, 2007.

On November 19, 2003, Claimant and Palm Beach County School District (Employer) entered into a settlement agreement whereby Employer/Carrier agreed to pay Claimant a lump sum in exchange for Claimant's agreement to release Employer/Carrier from further claims. The parties agreed that Employer/Carrier would be responsible for payment of indemnity (if applicable) and for the provision of authorized medical treatment and care through the date of Judge of Compensation Claims approved the attorney fee stipulation.

Furthermore, Employer/Carrier agreed to set up and fund a Medicare Set Aside Trust to satisfy any Medicare claims and indemnify Claimant and her attorney. Subsequently, on December 1, 2003, Claimant filed a petition for benefits asking Employer/Carrier to pay for her share of two bills Medicare had covered prior to the settlement agreement.

On December 11, 2003, the judge of compensation claims approved the attorney fee stipulation finalizing the parties' settlement agreement. Employer/Carrier initially disputed Claimant's entitlement to the payment of her share of the two medical bills submitted to Medicare. Mediation to resolve the dispute regarding the bills was unsuccessful. However, after, Employer/Carrier agreed to hold Claimant harmless against any Medicare claims.

Claimant filed a motion for attorney's fees seeking payment for time spent for mediation and securing the hold harmless agreement. The Judge of Compensation Claims denied the Motion on January 23, 2007, stating she did not have jurisdiction to adjudicate

disputes arising from the release agreement executed in December of 2003.

The First District Court of Appeal reversed and remanded the JCC's order stating that the Judge erred as a matter of law because the terms of the agreement present a question of law. Furthermore, the terms of the settlement agreement did not preclude the JCC from deciding whether the parties followed the agreement. Therefore, the case was remanded to the JCC to determine the validity of Claimant's motion for attorney fees.

WORKERS' COMPENSATION CLAIMS LIMITED: The Judge of Compensation Claims erred by ruling on issues not properly raised within a petition for benefits or within a pretrial stipulation.

Hooten v. AAA Cooper Transportation/Crawford & Co., 32 Fla. L. Weekly D 2915, decided December 21, 2007.

Claimant injured on May 13, 1997 filed a petition for benefits on December 20, 2002 requesting permanent total disability (PTD) benefits. Employer/Carrier administratively had accepted Claimant as permanently totaled disabled on January 28, 2001. At the Final Hearing held on March 22, 2006, the judge of compensation claims, sua sponte, without a motion being made by either party, added a claim for payment of supplemental permanent total disability benefits.

A final order was entered on July 26, 2006 awarding Claimant the requested permanent total disability supplemental benefits plus penalties and interest. Claimant's request for entitlement to attorney fees related to the administrative acceptance of PTD was denied. However, the JCC awarded attorney fees and costs for obtaining the supplemental benefits.

Claimant appealed the denial of attorney's fees for the administrative acceptance and Employer cross appealed for the sua sponte inclusion of the supplemental benefits claim.

The First District Court of Appeal affirmed the JCC's denial of attorney's fees and costs for the administrative acceptance because substantial evidence and Florida Law support the findings of fact of administrative acceptance prior to the filing of the petition for benefits. Furthermore, the Court held that the JCC abused his discretion in sua sponte awarding the entitlement to supplemental benefits when the parties' agreement documented that the subject of PTD supplemental benefits was not even scheduled for consideration at the hearing. Therefore, the issue was not properly before the JCC at the time of the final hearing.

The First District Court of Appeal reversed the award of PTD supplemental benefits, penalties, interest, and attorney's fees and costs and affirmed the denial of attorney's fees for the administrative acceptance of PTD benefits.

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