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LEGAL UPDATE

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CASE SPOTLIGHT ON STATE FARM v. ADAMS

By Robert M. Darroch, Adam C. Joffe and Elliot D. Tiller

In our last edition of Legal Update, we briefly discussed the Court of Appeals decision in Adams v. State Farm Mut. Auto. Ins. Co., 298 Ga. App. 249, 679 S.E.2d 726 (2009), in the broader context of ERISA liens and subrogation. In Adams, the Court of Appeals held that payments made by an at-fault driver's auto liability insurer to satisfy a hospital lien (for services rendered to the claimant) constitute "payment of other claims or otherwise," and thus, the claimant's insurer is not entitled to set off uninsured motorist (UM) coverage by the amount paid to satisfy the lien.

The facts of Adams were as follows: Adams, a State Farm insured, got into a car accident and sued the other driver. During the course of the underlying litigation, Nationwide, the tortfeasor's automobile liability insurer, made two payments that exhausted its $25K policy limits: $9K to Grady Hospital to compromise its hospital lien for medical services provided to Adams and $16K to Adams for a limited release. Adams then looked to State Farm for additional compensation under his UM coverage. State Farm contended it should be able to set off or take credit for the entire $25K paid by Nationwide, but Adams contended that State Farm should only get credit for the $16K paid to him personally and not the $9K paid by Nationwide directly to Grady Hospital to satisfy its lien. The trial court granted summary judgment to State Farm on the issue and Adams appealed.

The Court of Appeals, to the surprise of many, reversed the trial court and held that, because payments made by the liability carrier directly to the claimant's medical providers constitute "payment of other claims or otherwise," a UM carrier is not entitled to any setoff against those payments. The Court of Appeals analogized to the Supreme Court's decision in Thurman v. State Farm (discussed in greater detail below), in which it was held that, when a federal employee is required by Federal laws to reimburse the provider of benefits and the federal employee has not been fully compensated for injuries sustained, the amount reimbursed to the benefits provider constitutes a reduction in the limits of coverage of the tortfeasor's liability insurance "by reason of payment of other claims *or otherwise*." By extending this reasoning to payments made directly to the claimant's medical providers, the Georgia Court of Appeals instantly and significantly expanded UM coverage in those situations where a claimant's medical provider has filed a lien.

LEGAL UPDATE is a review of recent judicial and legislative developments in areas affecting the insurance claims community. It is not the intention of LEGAL UPDATE to provide an exhaustive report on all cases relevant to insurance defense or to offer legal advice. Readers should not rely on cases cited in LEGAL UPDATE without checking the current status of the law. LEGAL UPDATE was created for clients of Goodman McGuffey Lindsey & Johnson, LLP and the possibility of circulation beyond the firm's clientele should not be construed as advertisement.

The Georgia Supreme Court agreed to hear Adams and they issued their decision on November 30, 2010. The Supreme Court overruled the Court of Appeals and said hospital liens **do not** reduce the liability limits applicable to set off the UMBI limits. State Farm Mut. Auto. Ins. Co. v. Adams, 288 Ga. 315, 702 S.E.2d 898 (2010). As indicated, the Court previously in Thurman v. State Farm Mut. Auto. Ins. Co., 278 Ga. 162, 598 S.E.2d 448 (2004), determined that federal postal employee health insurer lien claims reduce the liability limits applicable to set off the UMBI limits. Then in 2008, the Georgia Court of Appeals extended the Supreme Court's Thurman decision to include Medicare lien claims. Toomer v. Allstate Ins. Co., 292 Ga. App. 60, 663 S.E.2d 763 (2008). Importantly, both Thurman and Toomer involved federal lien claims.

In Thurman, the Georgia Supreme Court recognized that federal liens, or liens created by federal law, were not subject to Georgia's "complete compensation rule." As the Supreme Court explained, "when Georgia law is applicable, an injured party's medical insurer and the workers' compensation carrier of the injured party's employer are not permitted to seek reimbursement from the injured party unless and until the amount of the settlement received by or the judgment awarded to the injured party exceeds the injured party's economic and noneconomic damages." Thurman, 278 Ga. at 164. Even so, the Georgia Supreme Court crafted the following rule in an effort to achieve a similar outcome:

> While Georgia law cannot bar the federal government and its insurance carriers from obtaining reimbursement from the federal worker injured in a motor vehicle collision on the job for benefits paid to her regardless of whether she has been fully compensated for the injuries sustained, Georgia law can mitigate the financial harm inflicted by the federal policy and effectuate, as best it can under the circumstances, Georgia's public policy of complete compensation. The legislature has provided the means by its use of the phrase "reduced by payment of claims or otherwise" to describe payments that reduce the amount of "available coverages" under the tortfeasor's liability policy. Accordingly, we conclude that when a federal employee is required by FECA or FEHBA to reimburse the provider of benefits and the federal employee has not been fully compensated for injuries sustained, the amount reimbursed to the benefits providers constitutes a reduction in the "limits of coverage [of the tortfeasor's liability insurance] … by reason of … or otherwise." Id.

Basically, the Court decided that it cannot overrule a federal right to reimbursement, but that it could interpret the UM statute to create additional UM exposure so the injured can increase his or her net recovery as if the "complete compensation rule" applied.

In Adams, the Georgia Supreme Court departed from its analysis in Thurman and instead compared liens that attach to the plaintiff's cause of action versus third-party subrogation claims. The Court looked at Georgia's hospital lien statute and said:

> At its most basic level, this statute recognizes that a hospital is entitled to directly bill the patient for its services and to rely solely on the patient to pay for medical services rendered. To ensure payment to the hospital, the statute grants the hospital a lien against a patient's cause of action. This cause of action refers to the patient's recourse against a tortfeasor for causing the patient's injuries. This recourse is represented by a claim brought against a tortfeasor for personal injuries and associated economic damages, such as a hospital bill. In turn, the tortfeasor, where insured, may look to his insurance company to make liability payments to the patient to cover the patient's economic damages. These liability payments, in turn, are subject to the hospital's lien seeking reimbursement for services directly billed to the patient. In short, the lien allows the hospital to step into the shoes of the insured for purposes of receiving payment from the tortfeasor's insurance company for economic damages represented by the hospital bill. Id. at 316.

The Court concluded that a hospital lien is part of the plaintiff's economic damages and, therefore, is not an "other claim or otherwise" under the UM statute. The Court seems to have created a distinction between medical providers and insurers, and then even between insurers for those that are subject to the "complete compensation rule" and those that are not.

After Adams, we now know that hospital bills that may or may not result in a hospital lien will not create additional UM exposure. What is not completely resolved by Adams or Thurman is whether the Medicaid lien creates UM exposure.

The Georgia Supreme Court looked at the hospital lien statute in Adams and determined it only gave the hospital a lien on the plaintiff's cause of action and not a third-party right of recovery. Here is the hospital lien statute:

> (b) Any person, firm, hospital authority, or corporation operating a hospital, nursing home, or physician practice or providing traumatic burn care medical practice in this state shall have a lien for the reasonable charges for hospital, nursing home, physician practice, or traumatic burn care medical practice care and treatment of an injured person, which lien shall be upon any and all causes of action accruing to the person to whom the care was furnished or to the legal representative of such person on account of injuries giving rise to the causes of action and which necessitated the hospital, nursing home, physician practice, or provider of traumatic burn care medical practice care, subject, however, to any attorney's lien. ***The lien provided for in this subsection is only a lien against such causes of action and shall not be a lien against such injured person, such legal representative, or any other property or assets of such persons and shall not be evidence of such person's failure to pay a debt.*** This subsection shall not be construed to interfere with the exemption from this part provided by Code Section 44-14-474.

Now compare the hospital lien statute to the Department of Community Health statute:

> (a) ***The Department of Community Health shall have a lien for the charges for medical care and treatment provided a medical assistance recipient upon any moneys or other property accruing to the recipient to whom such care was furnished or to his legal representatives as a result of sickness, injury, disease, disability, or death, due to the liability of a third party, which necessitated the medical care.***
>
> (b) The department may perfect and enforce any lien arising under subsection (a) of this Code section by following the procedures set forth for hospital liens in Code Sections 44-14-470 through 44-14-473; except that the department shall have one year from the date the last item of medical care was furnished to file its verified lien statement; and the statement shall be filed with the appropriate clerk of court in the county wherein the recipient resides and in Fulton County. The verified lien statement shall contain the following: the name and address of the person to whom medical care was furnished; the date of injury; the name and address of the provider or providers furnishing medical care; the dates of services; the amount claimed to be due for the care; and, to the best of the department's knowledge, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries. This Code section shall not affect the priority of any attorney's lien.
>
> (c) ***The department shall be subrogated***, but only to the extent of the reasonable value of the medical assistance paid and attributable to any sickness, injury, disease, or disability, to the rights of medical assistance recipients to any benefits provided such recipients by virtue of private health care insurance contracts; provided, however, the right of subrogation does not attach to any recipient's rights to benefits paid or provided

under private health care coverage prior to the receipt of written notice, by the carrier who issued the health care contract, of the exercise by the department of its subrogation rights.

> (d) A recipient of medical assistance who receives medical care for which the department may be obligated to pay ***shall be deemed to have made assignment to the department of any rights of such person to any payments for such medical care from a third party***, up to the amount of medical assistance actually paid by the department; provided, however, assignment does not attach to a recipient's right to any payments provided under private health care coverage prior to the receipt of written notice, by the carrier who issued the health care coverage, of the exercise by the department of its assignment. This subsection shall apply to a recipient only if notice of this subsection is given to the recipient at the time his application for medical assistance is filed. The assignment created by this subsection shall be effective until the recipient of medical assistance is no longer an eligible recipient for medical assistance. O.C.G.A. § 49-4-149.

While the hospital lien statute only gives the hospital a lien against the plaintiff's cause of action, the Medicaid statute gives the Department of Community Health a lien, a subrogation claim and an assignment of the plaintiff's rights to the extent of the Medicaid payments. Arguably, Adams should apply to the lien claim because Medicaid is a program created under state law and the lien attaches to the cause of action the same as a hospital lien.

The difference with Medicaid is that the Department of Community Health also has a *subrogation* claim and gets an assignment. That means the Department of Community Health can bring its own claim that could arguably be construed as an "other claim or otherwise" similar to a federal lien claim, and unlike most insurers in Georgia and similar to federal health insurance plans, Medicaid is not subject to the "complete compensation rule." Padgett v. Toal, 261 Ga. App. 154, 581 S.E.2d 744 (2001). As you can see, it is not a federal plan, but it has similar characteristics to the plan in Thurman.

If the Georgia Supreme Court was asked to address this issue, we think the Court would lean toward Thurman. Looking ahead, this could very well be the next issue on appeal in the evolution of lien claims and their effect on the UM statute.

SOUTH CAROLINA SUPREME COURT HOLDS THAT CONSTRUCTION DEFECTS ARE NOT AN OCCURRENCE UNDER A CGL POLICY UNLESS DAMAGES ARE FORTUITOUS

By Robert M. Darroch

In the recent decision of Crossman Communities of North Carolina, Inc. v. Harleysville Mutual Insurance Co., No. 26909, 2011 WL 93716 (S.C. Jan. 7, 2011), the South Carolina Supreme Court abrogated its prior holding in Auto-Owners Insurance Co., Inc. v. Newman, and held that defective construction does *not* constitute an occurrence unless the resulting damages are "fortuitous."

Crossman Communities of North Carolina, Inc. ("Crossman") was the developer of a series of condominium projects in Myrtle Beach, South Carolina. In 2001, after construction was completed on five projects, various homeowners sued Crossman, alleging that the condos were defectively constructed, leading to their decay and deterioration as a result of water infiltration. Crossman settled the case for approximately $16.8 million and sought coverage from its CGL carrier, Harleysville. The trial court found that "there was property damage that resulted from, and was in addition to, the subcontractors' negligent work itself, and thus, the property damage was caused by an occurrence." The Supreme Court of South Carolina reversed.

The Court noted that the issue of whether a CGL policy provides coverage for faulty work and damages stemming from faulty work is a difficult issue that has resulted in an "intellectual mess." In its view, courts across the country have taken two positions on the issue: (1) claims of poor workmanship, standing alone, are not occurrences, although coverage is triggered where faulty workmanship causes bodily injury or property damage to a third party's property; and (2) damage flowing from faulty work constitutes an occurrence, regardless of the property injured, so long as the insured did not intend or expect the result.

The Crossman court explicitly overruled its prior decision in Auto-Owners Insurance Co., Inc. v. Newman, 684 S.E.2d 541 (S.C. 2009), in which it held that, although the defective application of stucco to a home's exterior "did not on its own constitute an occurrence, the continuous moisture intrusion resulting from the subcontractor's negligence was an occurrence." The Crossman court examined the "fortuity" element of the definition of "occurrence," and stated its new rule:

> We hold that where the damage to the insured's property is no more than the natural and probable causes of faulty workmanship such that the two cannot be distinguished, this does not constitute an occurrence.

The Court held that Crossman had not shown an occurrence—although the water intrusion may have been a continuous exposure to substantially the same harmful conditions, it was not an unexpected/unintended event because the natural consequence of Crossman's faulty work was the damage to the condominiums.

The Crossman case does little to clarify the so-called "intellectual mess" of defective-construction-as-an-occurrence case law. The Court, adopting Harleysville's example, provided the following example of a covered loss in an attempt to clarify the issue:

> Assume the insured is a general contractor that built an apartment building using various subcontractors to complete the work. Also assume a subcontractor installed all wiring in the apartment building. After the building is complete and put to its intended use, a defect in the building's wiring causes the building to sustain substantial fire damage. In such an instance, an occurrence would exist, the insurer could point to the "your work" exclusion, but then the "subcontractor exception" would provide an exception to the exclusion.

The Court went on to state that the example illustrates "fortuitous events that were caused by faulty workmanship" resulting in coverage.

Thus, under Crossman, obtaining coverage for losses stemming from defective or faulty work in South Carolina will now require a two-step process: (1) showing that the faulty work damaged something other than the faulty work itself and (2) demonstrating that the damage was fortuitous and not the "natural and probable" result of the faulty work.

CASE NOTES

Georgia Liability

TORTS/SLIP AND FALL: Question of whether defendant's actions constituted spoliation of evidence had no bearing on whether defendant had actual or constructive knowledge of foreign substance for premise liability purposes.

Fred's Stores of TN, Inc. v. Davenport, 2010 WL 4723379 (Ga. App. A10A1554), decided November 23, 2010.

Barbara Davenport alleged that she slipped and fell on a paper clip at a Fred's grocery store. After the fall, the store manager came to the scene. He allegedly said there was nothing on the floor. When the paper clip was pointed out to him, he picked it up, put it in his shirt pocket, and repeated that nothing was on the floor. The assistant store manager claimed she performed a periodic inspection of the area approximately two minutes before the fall and there was no paper clip on the floor at that time.

Fred's moved for summary judgment based on its lack of actual or constructive knowledge of the paper clip. The trial court denied summary judgment based on Fred's employee allegedly engaging in spoliation of evidence by removing the paper clip, reasoning that the spoliation may entitle Davenport to a presumption that the Fred's employee had actual or constructive knowledge of the alleged hazard. Fred's appealed to the Court of Appeals of Georgia.

The Court of Appeals addressed two issues: (1) whether Fred's had knowledge of the hazard and (2) the relevancy of any spoliation of evidence to the question of whether there was actual or constructive knowledge. Constructive knowledge can be shown in two ways: (1) an employee being in the vicinity of the fall and having an opportunity to correct the condition before the fall or (2) showing that the substance was on the floor for a sufficient period of time such that it reasonably should have been discovered. A plaintiff does not have to offer evidence of the second factor unless the defendant can show there were reasonable inspection procedures in place and followed at the time of the incident.

Davenport did not refute Fred's evidence that an employee was in the same area minutes earlier during a routine inspection and the floor was clear at that time. Therefore, the Court held that Davenport did not establish actual or constructive knowledge and that summary judgment should have been granted to Fred's.

The Court next addressed the spoliation issue. Assuming there even was spoliation, the Court did not agree that the store manager's actions were relevant to the question of constructive knowledge of the paper clip *before* the fall occurred.

The Court relied on the case of Craig v. Bailey Bros. Realty, 304 Ga. App. 794 (2010), wherein a child's foot was impaled on a protruding spike in a retaining wall. After the accident, the property owner inspected the wall, hammered down protruding spikes, and cleared away obscuring vegetation. The plaintiff claimed the owner's actions constituted spoliation of evidence. However, the Court in *Craig* held that the plaintiff failed to establish the necessary causal link between the alleged spoliation and any prejudice on his underlying premise liability claims.

Here, the Court stated that the only inference that could be drawn from the manager's alleged destruction of evidence would be that the paper clip was on the floor when he came to the scene *after* the fall, not that it was on the floor when the area was inspected before. The alleged spoliation had no effect on whether Fred's had knowledge *after* the fall that the paper clip was on the floor. The Court therefore reversed the trial court's denial of summary judgment.

TORTS/DAMAGES/SETOFF: Defendant is entitled to setoff for pain and suffering portion of prior settlement only, where estate is plaintiff.

Mays v. Kroger Co., 306 Ga. App. 305, 701 S.E.2d 909 (2010).

Carry Lee Mays purchased seizure medication from a Kroger pharmacy. The pharmacist filled the prescription incorrectly and Mays was hospitalized. The hospital administered medication intravenously. The hospital medication caused Mays further injury and eventually killed her.

Kroger settled with Mays' estate for $120,000 before trial. The settlement consisted of $105,000 to Mays' heirs for her wrongful death and $15,000 to the estate for pain and suffering. Mays' estate proceeded to trial against the hospital and obtained a $150,000 verdict for pain and suffering.

In a prior appeal, the Georgia Court of Appeals held that Kroger and the hospital were joint tortfeasors and remanded the case to the trial court for a determination of the setoff to which the hospital was entitled. The trial court held that the hospital was entitled to a setoff of the full $120,000 settlement with Kroger. The estate appealed.

The issue on appeal was whether the hospital was entitled to a setoff equal to the full amount of the Kroger settlement or only the portion of the settlement allocated to the estate for pain and suffering ($15,000). The Court of Appeals sided with the plaintiff and held that the hospital was only entitled to a setoff of the $15,000 allocated for pain and suffering. The Court relied on the rule that a pain and suffering claim belongs to the estate, whereas a wrongful death claim belongs to the heirs.

It is important to consider this decision (assuming it does not get reversed in the Supreme Court) when resolving not to settle a wrongful death claim where settlement has been reached with other defendants. In such situations, it is important to pay attention to the terms of the settlement and the verdict form. In Mays, if the hospital had requested a verdict form with separate lines for pain and suffering and wrongful death, the jury may have awarded damages for both. If the jury had split its verdict between pain and suffering and wrongful death, the hospital would have been entitled to a larger setoff.

TORTS/DAMAGES/APPORTIONMENT: Tort Reform Act of 2005 eliminated claims for contribution and setoff against co-defendant and replaced it with process of apportionment.

McReynolds v. Krebs, 2010 WL 4723417 (Ga. App. A10A1155), decided November 23, 2010.

Plaintiff Lisa Krebs was seriously injured in a motor vehicle accident when her Chevrolet Trailblazer rolled into a ditch after being hit by a car driven by McReynolds. Krebs sued McReynolds and General Motors, alleging that a design defect in the vehicle contributed to her injuries. McReynolds filed a cross-claim against GM for setoff and contribution.

During the pendency of the lawsuit, GM settled with Krebs and Krebs dismissed GM from the suit. GM then moved to dismiss

McReynolds' cross-claim against it, contending that the revised apportionment statute (O.C.G.A. § 51-12-33) had abolished joint and several liability in Georgia. McReynolds argued that the apportionment statute was inapplicable because it only applies in cases where the plaintiff's own negligence contributed to her injuries and that, even if the statute did apply, it did not eliminate her right to contribution or setoff under the contribution and indemnity statute (O.C.G.A. § 51-12-32).

O.C.G.A. § 51-12-33, as modified by the Tort Reform Act of 2005, requires the jury to consider the fault of all persons who may be partially responsible for the plaintiff's injuries, including *non-parties* who are either (1) identified in writing at least 120 days before trial or (2) with whom plaintiff entered into a settlement agreement before trial. The statute then requires the jury to apportion damages among the *party* defendants according to their percentage of fault after determining the relative fault of *all* persons and entities who contributed to the injury.

O.C.G.A. § 51-12-32, as amended, provides for contribution and indemnity from joint trespassers "except as provided in Code Section 51-12-33," which appears to do away with contribution and indemnity among joint tortfeasors altogether.

At the hearing on GM's motion, the trial court indicated that McReynolds could "present a case as to apportionment" against non-party GM at trial. Nevertheless, McReynolds continued to assert that she was entitled to setoff or contribution. GM argued that the law now called for apportionment based on a percentage of fault; that setoff and contribution were no longer allowed; and that under apportionment, it was not required to be a party. Following arguments, the court granted GM's motion to dismiss on the ground that the Tort Reform Act of 2005 abolished joint and several liability and, therefore, setoff and contribution were inapplicable.

In the pretrial order, McReynolds continued to pursue claims for setoff and apportionment against GM and she did not state a claim for apportionment. At the beginning of trial, McReynolds admitted she had no evidence regarding GM's potential liability and the court granted Krebs's motion in limine to exclude from evidence at trial any mention of the allegations originally made against GM. The jury found against McReynolds and the court entered judgment against her in the full amount of the verdict.

On appeal, the Court of Appeals held that the apportionment statute is applicable even where the plaintiff bears no fault. Furthermore, under the clear wording of the statute, GM was not required to be a party to the suit after it settled, and McReynolds had no claim of setoff or contribution, given that the statute requires each liable party to pay its own percentage share of fault and McReynolds presented no evidence regarding GM's alleged fault. As a result, the jury heard no evidence upon which it could possibly apportion any damages to GM. Accordingly, the trial court did not err in granting GM's motion to dismiss or in entering the full amount of the judgment against McReynolds.

This case represents a victory for the defense bar in the face of continued challenges being raised to the new apportionment statute, which eliminates joint and several liability in Georgia and seeks to hold each defendant liable for a given injury only to the extent of that defendant's percentage share of fault.

TORTS/EMOTIONAL DISTRESS/IMPACT RULE: For medical malpractice cases, impact rule is not applicable to claims for negligent infliction of emotional distress. Also, plaintiff is not barred from profiting from his crime unless he is guilty of intentionally killing while sane.

Bruscato v. O'Brien, 2010 WL 4883659 (Ga. App. A10A1230), decided December 2, 2010.

The impact rule usually governs claims for negligent infliction of emotional distress. Where a plaintiff sues for mental distress caused by negligence, Georgia usually requires that the

plaintiff receive a physical impact, that the impact cause a physical injury, and that the physical injury cause mental distress to the plaintiff. (A very limited exception is that a parent can recover for mental distress caused by witnessing an impact to his or her own child.)

This three-prong impact rule was created for several public policy reasons. First, the courts feared that, without those criteria, there would be a flood of litigation by bystanders claiming they experienced emotional distress from an incident. By limiting recovery to people who received a physical impact, much unwanted litigation would be avoided. Second, the courts were concerned that emotional distress without physical injury would lead to fraudulent claims. Third, the courts feared it would be difficult to determine whether emotional distress was caused by an incident that was not accompanied by physical impact.

In Bruscato, the plaintiff was a psychiatric patient who sued his psychiatrist for mental distress which allegedly was caused by the doctor's negligent discontinuation of medication, leading to psychiatric symptoms. The doctor obtained summary judgment from the trial court, because the court held that the impact rule applied and that the plaintiff did not experience a physical impact which caused the emotional distress.

The Court of Appeals reversed, holding that the impact rule does not apply to medical malpractice actions because the public policy considerations underlying the impact rule are inapplicable. Because a medical malpractice action requires there be a doctor-patient relationship between the plaintiff and the defendant, there could not be a flood of litigation filed by bystanders if the impact rule were lifted for those types of cases.

The Court also held that the impact rule is not necessary to avoid frivolous or fraudulent malpractice claims, since plaintiffs in malpractice actions are required to support their lawsuits with affidavits from experts who testify that the defendant violated the standard of care.

A second issue in Bruscato addressed the public policy that a plaintiff should not be permitted to recover damages resulting from his own criminal misconduct. After the plaintiff experienced psychosis allegedly as a result of the discontinuation of medication, he brutally killed his mother and then sued his doctor for his mental distress. The trial court granted summary judgment, holding that the plaintiff's crime barred him from recovering for his mental distress.

The Court of Appeals reversed for two reasons. First, the plaintiff may have experienced some mental distress from his psychosis unrelated to his mother's death, so the rule against profiting from a crime would not bar him from recovering those damages. Second, the rule does not bar all people from profiting from all crimes. The public policy barring a criminal from benefitting from his crime is limited to instances of intentional and criminal murder or voluntary manslaughter. Instances such as negligent homicide, self defense or homicide while insane are not included in the bar. Therefore, jury issues remained as to whether the plaintiff was barred from recovering for damages stemming from his mother's death. Because the plaintiff had not yet been convicted of murder and issues of fact remained such as to his sanity, summary judgment was improper.

TORTS/EVIDENCE/DISCOVERY: In medical malpractice action, defense counsel is permitted to informally communicate *ex parte* with plaintiff's medical providers about plaintiff's medical conditions, so long as trial court enters protective order limiting scope of communications to medical conditions at issue in case and governing use of information during and after trial.

Baker v. WellStar Health System, Inc., 2010 WL 4272843 (Ga. S10A0994), decided November 1, 2010.

Russell Baker brought a medical malpractice action against WellStar Health Systems, Inc. In order to prepare for trial, WellStar moved for a qualified protective order under the Health Insurance Portability and Accountability Act (HIPAA). The proposed

order sought to permit WellStar to informally communicate with Baker's medical providers outside of the presence of Baker or his counsel ("*ex parte*") for those communications. After a hearing, the trial court granted WellStar's motion, reasoning that HIPAA permitted WellStar to communicate with Baker's medical providers without Baker or his counsel being present, so long as safeguards were in place to protect Baker's medical information. Baker filed an interlocutory appeal to the Georgia Supreme Court.

The Supreme Court held that although the protective order satisfied HIPAA, it did not comply with Georgia law because it was not limited in scope to those medical conditions relevant to the medical malpractice action.

Under HIPAA, one way that defense counsel may informally interview the plaintiff's treating physicians is to obtain a qualified protective order. A qualified protective order prohibits the use of the plaintiff's medical information for any purpose outside of trial and requires either the return or destruction of the information at the end of the trial.

In this case, WellStar complied with HIPAA because it actually obtained a qualified protective order from the trial court. As required by HIPAA, the order limited WellStar's use of the information to the trial only and required the destruction of the information at the end of the case.

However, the protective order failed to comply with Georgia law because it was too broad in scope, permitting WellStar to discuss past, present, and future treatment of Baker without any consideration of its relatedness or relevancy to the medical practice action. In proceedings in which a litigant's medical condition is at issue, Georgia law generally permits *ex parte* communications between the litigant's treating physicians and opposing counsel, under the theory that the litigant's right to medical privacy *as to the condition at issue* has been waived. Therefore, in order to comply with Georgia law, the order should have limited WellStar's informal communications to those matters that were relevant to the medical condition at issue in the medical malpractice action.

In its opinion, the Supreme Court offers some specific guidance to the trial courts. When a trial court enters a qualified protective order, the order should include the following information: (1) which medical providers may be interviewed; (2) the conditions at issue in the medical malpractice action; (3) a statement that the interview is at the request of the defendant for the purpose of assisting defense counsel; and (4) a statement that the health care provider's participation is voluntary. Depending upon the circumstances of the case, the protective order may also need additional provisions (e.g., requiring the transcription of the interview by a court reporter at the plaintiff's request). The Court reasoned that these additional provisions will both advance HIPAA's purposes and comply with Georgia law, while at the same time permitting informal discovery that may be helpful to the litigation process.

TORTS/PREMISES LIABILITY: Alleged peril hidden only by darkness does not constitute a "pitfall" or a "mantrap" with respect to landowner's liability to licensee.

Jones v. Murphy, 306 Ga. App. 539, ---S.E.2d ---, decided Oct. 21, 2010.

Shelly Murphy was in the process of moving into her new house and had several friends over to celebrate. That evening, the group was gathered on the candlelit back porch of the home while the inside of the home remained unlit.

Around 10:00 p.m., Richard Jones arrived with his fiancé to show Murphy the fiancée's engagement ring. Jones entered rather excitedly to show off the ring and walked quickly through the unlit living room toward the back porch, where the group was gathered.

The porch was accessible by a sliding glass door fitted with a swinging metal security gate. Jones observed that the security gate was open but did not realize the glass door was closed. Jones subsequently crashed through the glass door while attempting to enter the porch and injured his leg.

Jones sued Murphy, alleging that she failed to make the sliding glass door safe to visitors and failed to warn him of its dangerousness. Murphy filed a motion for summary judgment, which the trial court granted. Jones appealed and the Court of Appeals affirmed.

Under O.C.G.A. § 51-3-2(b), "[t]he owner of the premises is liable to a licensee only for willful or wanton injury." This statutory liability for willful or wanton injury to licensees means that the landowner owes a duty "only to avoid knowingly letting [the licensee] run upon a hidden peril or willfully causing him harm."

Jones took the position that the glass door constituted a "hidden peril" in his friend's darkened home. However, the Court noted that Jones was certainly aware that the room was dark and should have taken better care to avoid injury to himself in light of this knowledge. Jones's own actions in walking through a "pitch black" room and attempting to exit onto a dimly lit porch in total darkness clearly showed his failure to exercise reasonable care for his own safety. Accordingly, even if the glass door could be considered a "hidden peril," it was only so because it was hidden in the same darkness of which Jones himself was aware, thus barring any recovery for his injuries.

TORTS/PREMISES LIABILITY: Landlord not liable to third parties for damages arising from tenant's negligence when landlord fully parts with possession and right of possession of premises.

Lake v. APH Enterprises, LLC., 306 Ga. App. 317, 702 S.E.2d 654 (2010).

On the evening of March 6, 2007, Foster Lake, Jr. was a patron at The Sports Zone Bar & Grill in Albany, Georgia. In the early hours of March 7, Lake was trying to break up a fight in the bar parking lot when he was shot by an unknown assailant. Lake filed suit against the bar owner and operator, Curtis Marshall, and the landlord of the property, APH Enterprises, LLC.

Evidence at trial showed that APH purchased the premises where the bar was located in 2005. APH entered into a verbal lease with Marshall in which they agreed that the lease would continue under the same terms that Marshall had with the previous landlord. Pursuant to that agreement, Marshall was responsible for providing security and day-to-day maintenance of the premises, including the parking lot. APH was responsible for repairing "major problems" with the building itself, such as a broken air conditioning unit or a leaky roof. The facts showed that Alex Rowe, APH's owner, only walked over to the bar a few times over the years to see how it was doing. Also, APH paid property taxes for the premises, deducted repair expenses, and maintained insurance on the building where the bar was located.

Lake alleged in his complaint that both the bar owner (Marshall) and the landlord (APH) were negligent under O.C.G.A. § 51-3-1 for failing to exercise ordinary care in keeping the bar's premises and approaches safe.

APH moved for summary judgment, asserting that it was an "out-of-possession" landlord and therefore not liable to Lake for damages resulting from any purported negligence of the bar owner in keeping the parking lot safe. The landlord argued that it was protected from liability by O.C.G.A. § 44-7-14, which states: "Having fully parted with possession and the right of possession, the landlord is not responsible to third persons for damages resulting from the negligence or illegal use of the premises by the tenant." The trial court granted summary judgment for APH on the ground that it had fully parted with possession of the leased property. Lake appealed the ruling, claiming there was a question of fact as to whether APH had fully parted with possession of the property.

The Court of Appeals affirmed the trial court's decision, holding that even though APH paid the property taxes and had the right to inspect the property, the "right to inspect is not the equivalent of the right to possess premises, so as to make the landlord liable." The Court likened this case to another Georgia suit where the Court held that a landlord was not liable for a dog bite that occurred in the tenant's yard, even though the landlord was responsible for maintaining the 'structure' while the tenant was

responsible for maintaining the yard. *See* Webb v. Danforth, 234 Ga. App. 211 (1998).

TORTS/PREMISES LIABILITY/EQUAL KNOWLEDGE: Where dangerous condition of premises is known or knowable to plaintiff by exercise of ordinary care, premises owner will not be held liable for injuries resulting therefrom.

Barnes v. Morgantown Baptist Assoc., Inc., 2010 WL 4484615 (Ga. App. A10A1092), decided November 10, 2010.

On September 26, 2005, Brian Lackhouse was fatally injured when, while riding his bicycle in a shopping center parking lot, he and his bicycle fell roughly 12 feet from the top of a retaining wall onto the pavement below. On the day of the incident, Lackhouse and his friend, Josh Lambert, rode their bikes to the bicycle shop, which was located in the shopping center at the top of the retaining wall. According to Lambert, he and Lackhouse had driven to the bicycle shop five or six times during the preceding year and the retaining wall was readily visible during the drive there.

Lackhouse's mother and sister ("plaintiffs") brought a wrongful death action against the co-owners of the retaining wall ("defendants"), alleging that the defendants' failure to erect a fence or protective barrier at the top of the retaining wall constituted negligence, negligence per se and a nuisance.

The trial court granted summary judgment in favor of the defendants, finding that the retaining wall was an open and obvious condition that could have been avoided by Lackhouse in the exercise of reasonable care; that he also assumed the risk of his actions; and that the plaintiffs' claims of negligence, negligence per se and nuisance failed. The plaintiffs appealed.

In affirming the trial court's decision, the Court of Appeals reiterated the law in Georgia that an owner or occupier of land only has a duty to warn of hidden dangers or defects not readily observable to an invitee in the exercise of ordinary care. O.C.G.A. § 51-3-1. This duty is based entirely on the proprietor's superior knowledge of the hazard. If the invitee knows of a dangerous condition, there is no duty to warn the invitee of same and the proprietor will not be liable for injuries resulting therefrom because the invitee possesses the same knowledge of the hazard as the proprietor.

In this case, the retaining wall was an open and obvious static condition of which Lackhouse had actual knowledge. The danger of falling off the retaining wall was both apparent and avoidable by the exercise of reasonable care. As such, even if the defendants were negligent, negligent per se or caused a nuisance by failing to erect a fence or protective barrier at the top of the retaining wall, there still would be no liability imposed on them because they lacked *superior* knowledge of the hazard.

CIVIL PRACTICE/RENEWAL ACTIONS: If plaintiff chooses to dismiss fewer than all defendants, he must first obtain leave of court prior to dismissing remaining defendants or subsequent renewal action is subject to dismissal.

Kilgore v. Stewart, 2010 WL 4630653 (Ga. App. A10A1089), decided November 17, 2010.

Plaintiff Stewart filed a personal injury action against defendants John Kilgore and Walter Stansberry for injuries sustained in an automobile accident. On March 6, 2009, Stewart voluntarily dismissed Kilgore without first seeking court approval, which is required when a plaintiff seeks to dismiss fewer than all of the defendants to an action. Thirteen days later, Stewart also dismissed Stansberry. Shortly thereafter, Stewart filed a renewal action.

On June 16, 2009, after the renewal action was filed, the court stamped the dismissal of Kilgore "so ordered." Kilgore then moved to dismiss the renewal action on the grounds that Stewart failed to obtain a court order approving his dismissal of Kilgore prior to filing his renewal action. The trial court denied Kilgore's motion and Kilgore appealed.

On appeal, Kilgore argued that the trial court should have granted his motion to dismiss based on Stewart's failure to comply with O.C.G.A § 9-11-21. Under O.C.G.A § 9-11-21, a plaintiff must obtain leave of court to dismiss fewer than all defendants in a case. Because Stewart could not dismiss only one defendant without leave of court, Kilgore argued that Stewart's attempt to dismiss him was ineffective.

The Court of Appeals agreed and reversed the trial court's order denying Kilgore's motion on the grounds that Stewart's attempted dismissal of his original action was invalid. Stewart's initial dismissal of Kilgore was ineffective because he failed to obtain a court order. Furthermore, because Stewart's dismissal of Kilgore was ineffective, his subsequent dismissal of Stansberry was also ineffective. Consequently, the original action was still pending when Stewart filed his renewal action and the renewal action was subject to dismissal as a result.

CIVIL PRACTICE/RENEWAL ACTIONS: Delay in service of process in first action will not provide basis for dismissal of renewal action.

Robinson v. Boyd, 288 Ga. 53, 701 S.E. 2d 165 (2010).

On February 22, 2000, Gary Robinson backed his vehicle into another vehicle operated by Allen Boyd, Jr. On February 22, 2002 (the last day before the two-year statute of limitations expired), Boyd filed a complaint against Robinson and his employer, Eckerd Corporation, for personal injury and property damage arising from the accident. Boyd made no attempt to serve either defendant for nearly five years. Almost seven years after the accident, and almost five years after filing, Mr. Boyd finally perfected service of his complaint. He then promptly filed voluntary dismissals as to each defendant pursuant to O.C.G.A. § 9-11-41(a)(1)(A). Less than six months later, Boyd filed a renewal action against the defendants under O.C.G.A. § 9-2-61(a). O.C.G.A. § 9-2-61(a) provides that a plaintiff who voluntarily dismisses an action may renew the action within the applicable statute of limitations or within six months after dismissal, whichever is later.

Upon receipt of the renewal action, Robinson and Eckerd filed for summary judgment based on waiver, estoppel and the failure to exercise due diligence in perfecting service in the original action. Robinson and Eckerd also argued their due process rights were violated by the lengthy delay. The trial court granted summary judgment, finding that the renewal action was "barred by the doctrine of laches as Plaintiff's five-year delay in pursuing this action has prejudiced the Defendants' ability to prepare this case and violated their due process rights." Boyd appealed and the Court of Appeals reversed the trial court's decision based on Hobbs v. Arthur, 264 Ga. 359 (1994), finding that laches could not be used to grant summary judgment in this action at law, because "the equitable doctrine of laches does not apply to legal actions." A petition for certiorari review was then made to the Georgia Supreme Court.

The principal issue for the Supreme Court was the application of the decision in Hobbs v. Arthur, holding that, "inasmuch as diligence in perfecting service of process in an action properly refiled under O.C.G.A. § 9-2-61(a) must be measured from the time of filing the renewed suit, any delay in service in a valid first action is not available as an affirmative defense in the renewal action." After reviewing the different statutes enacted by the General Assembly on the issues of statute of limitations and renewal actions, and in light of its earlier decision in Hobbs, the Court found that untimely service in the original action is not available as a defense to a renewal action. A renewal suit is considered '*de novo*' (i.e., an entirely new suit) and defenses to the original action are inapplicable unless they would render the original action void and not merely 'voidable.' Whereas a complete lack of service in the original action prior to dismissal would make that action void, a *delay* in service ultimately perfected prior to dismissal would

not. As for the due process arguments, the Supreme Court did not believe that any constitutional violations had taken place. Finally, the Supreme Court found that Boyd was not equitably estopped from proceeding with the renewal action.

Based on the above, the Supreme Court determined that Mr. Boyd could proceed with his renewal action. This decision affirms what most have suspected was the case after the Supreme Court's decision in Hobbs, that the statute of limitations can be extended indefinitely via a renewal action, so long as a complaint is filed within the limitation period and is served *at some time* (in this case, nearly seven years after the incident giving rise to the complaint) prior to dismissing the original action.

Georgia Workers' Compensation

WORKERS' COMPENSATION/CAUSATION: Claimant carries burden to prove injury caused by work-related chemical exposure, and Superior Court cannot substitute itself as fact finder.

Hughston Orthopedic Hospital v. Wilson, 2010 WL 4069333 (Ga. App. A10A1098), decided October 19, 2010.

In May 2006, Wanda Wilson, who worked for Hughston Orthopedic Hospital as a clinical technician, was assigned to a floor where new wallpaper was being installed. On two occasions, she felt sick from the fumes from the wallpaper glue but she was able to keep working. On May 25, 2006, the fumes left her unable to breath and again feeling sick. Wilson was taken to the emergency room, where she fainted and was admitted to the hospital for further observation. According to Wilson, when she regained consciousness, she exhibited signs of brain injury, including an inability to talk or walk, as well as a headache. During Wilson's hospital stay, she underwent a battery of tests, all of which revealed normal brain functioning. Although she continued to experience problems after her discharge from the hospital, follow-up neurological tests continued to show normal brain functioning. Wilson never returned to work.

A neurologist who evaluated Wilson concluded that it was highly likely that her problems had a "psychogenic" or psychological (rather than physiological) origin. At the request of her attorney, however, Wilson consulted with another neurologist, Dr. Larry Empting. Dr. Empting, who met with Wilson only once and did not conduct any tests, concluded that Wilson had a chemical sensitivity to the wallpaper materials and that her exposure to these chemicals had caused lasting neurological problems.

Wilson subsequently filed a workers' compensation claim against the hospital and its insurer. Following an evidentiary hearing, the ALJ rejected Wilson's claim for benefits in a detailed order.

The ALJ, who had observed Wilson's demeanor and conduct while testifying, noted that Wilson "stuttered in a bizarre, sporadic pattern which appeared to be feigned," "would lapse into talking like a baby," "would speak in a very shrill, high pitched tone at times," and "on several occasions sounded as though she were speaking in tongues." The ALJ found that Wilson appeared "psychiatrically disturbed" on the witness stand and concluded that her "entire testimony with its bizarre speech seemed feigned, contrived and grossly exaggerated."

In the award, the ALJ pointed to evidence in the record reflecting that Wilson's problems were psychogenic in origin rather than the result of chemical exposure. Ultimately, the

ALJ concluded that while Wilson may have had a temporary adverse reaction to the wallpaper chemicals, she had failed to prove by a preponderance of the evidence that her persistent problems were caused by a work-related chemical exposure.

The Appellate Division adopted the ALJ's findings and conclusions. Wilson appealed to the Superior Court, which reversed. The Superior Court found that the Appellate Division had misconstrued the evidence and improperly substituted its lay opinion for that of the medical experts. The Superior Court remanded the case for a retrial. Hughston was granted discretionary appeal in the Court of Appeals.

The Court of Appeals held that factual questions concerning causation are properly left to the State Board to determine rather than to the superior court or the appellate courts. The State Board's findings must be affirmed if there is any evidence to support them. The ALJ found Wilson lacking in credibility and was not convinced by the testimony of Dr. Empting, the only physician who conclusively linked Wilson's symptoms to chemical exposure at work. Additionally, there was evidence supporting the conclusion that Wilson's symptoms resulted from psychological problems, rather than a brain injury caused by chemical exposure. Numerous tests showed normal brain functioning and at least one neurologist opined that Wilson's condition was highly likely to be psychological in origin.

While another fact finder might have reached a different conclusion, the record did not demand such a result and at least some evidence supported the ALJ's conclusions. Because the Superior Court improperly substituted itself as the fact finder in lieu of the ALJ, the Court of Appeals reversed the Superior Court's decision.

ENFORCEMENT AND MODIFICATION OF WORKERS' COMPENSATION AWARD: Superior Court does not have authority to modify terms of, or parties to, award of State Board.

Brannon v. Garcia, 2010 WL 4009971 (Ga. App. A10A1459), decided October 14, 2010.

After obtaining a favorable award from the State Board of Workers' Compensation, Garcia filed a "Petition to Adopt, Modify, and Enforce Order" in the Superior Court. The award attached to the petition showed that Daniel Garcia was the employee and Brennan Roofing Company was the employer. In the Award, the ALJ found that Garcia was an employee of "Brennan Roofing Company" and that "the claimant's supervisor, Mr. Gary Brennan, had notice of the accident on the day it occurred."

In his petition to enforce and modify the Award, Garcia styled the case as "*Daniel Garcia, Employee v. Brennan Roofing Co. [sic], Brannon Roofing Co., Employer, and Gary Brannon, Company Owner.*" After the Superior Court made the award of the State Board the order of the court, Garcia filed a motion "to correct a scrivener's error." In the motion, he asked the Superior Court to change the name of the employer in the award from "Brennan Roofing Company" to "Brannon Roofing Company." In a separate motion, Garcia also moved to add Gary Brannon as a party defendant.

The Superior Court granted both motions and Brannon appealed. He argued that the Superior Court abused its discretion and exceeded its authority both by modifying the Award issued by the ALJ and by substituting him as a party in a separate action to enforce the Award.

O.C.G.A. § 34-9-106 provides a mechanism for an interested party, who has been awarded benefits, to enforce an Award in the superior court in the county in which the injury occurred. The filing of such petition is not a separate suit, but rather a continuation of the State Board proceedings. A superior court lacks jurisdiction to hear, dispute or decide issues of fact that were determined in the State Board

proceedings and which provided the basis for an award.

As a result, the Court of Appeals held the Superior Court could not change the workers' compensation Award to add Brannon or to change the name of the employer and, accordingly, it reversed the decision of the Superior Court.

CONVERSION FROM TTD TO TPD DUE TO CHANGE IN CONDITION/PROCEDURAL REQUIREMENTS OF O.C.G.A. § 34-9-104: Employer can put injured worker on notice of intent to convert employee to TPD benefits within 60 days of any light duty release from authorized treating physician.

Imerys Kaolin Inc. v. Blackshear, 306 Ga. App. 491, --- S.E.2d ---, decided October 15, 2010.

Blackshear was working for Imerys Kaolin on May 24, 2001, when he injured both of his hands. Imerys Kaolin began paying Blackshear TTD benefits from the date of injury. On June 11, 2001, Blackshear's physician authorized him to return to work with restrictions. Based on the release, Imerys Kaolin informed Blackshear in January 2002 that his TTD benefits would be reduced to TPD effective June 4, 2002.

Recognizing it failed to send the appropriate notice to Blackshear within 60 days of the June 2001 release, Imerys Kaolin never actually reduced Blackshear's benefits in 2002. Instead, on December 31, 2002, Imerys Kaolin obtained a new release to work with restrictions based on an evaluation done in August 2002. Imerys Kaolin notified Blackshear on January 14, 2003, that his benefits would be reduced from TTD to TPD on December 31, 2003. Imerys Kaolin then suspended TTD benefits and eventually suspended TPD benefits when the maximum 350 week period expired.

In October 2008, Blackshear requested his TTD benefits be recommenced, contending he never received timely notification of the unilateral reduction to TPD benefits and therefore the reduction to TPD benefits was improper. The ALJ agreed, finding that the June 2001 and the December 2003 releases were substantively the same, and therefore Imerys Kaolin was required to notify Blackshear of the reduction within 60 days of June 11, 2001. Because it failed to do so, the ALJ reinstated Blackshear's TTD benefits and awarded them back to the date of the unilateral reduction in January 2004.

Imerys Kaolin appealed to the Appellate Division, which adopted the conclusions of law of the ALJ but stated that a new release could be relied upon if notice was given within 60 days. The second notice in this case was not given within 60 days.

On appeal to the Superior Court it held that that because Imerys Kaolin failed to file the appropriate notice forms within 60 days of the initial June 2001 release, Imerys Kaolin was barred from filing a subsequent Form WC-104 unless and until there was a change in Blackshear's status.

The Court of Appeals rejected the Superior Court holding that a change in the claimant's "status" was required. Neither the statute nor the rule places a limit on the number of times an employer may seek to reduce benefits based on substantially similar work releases.

The employer is required to strictly comply with the requirements of O.C.G.A. § 34-9-104(a)(2) and Board Rule 104. Because the notice provided to Blackshear was over five months after the last medical evaluation, benefits could not be reduced and the award of TTD benefits was proper.

WORKERS' COMPENSATION/CAUSATION: No workers' compensation liability arises from disability resulting from new accident unrelated to worker's employment.

Lowndes County Bd. of Comm. v. Connell, 305 Ga. App. 884, 701 S.E.2d 227 (2010).

Connell was an investigator with the Special Operations Division of the Lowndes County Sheriff's Office. While executing a warrant in March 2005, Connell slipped and fell, injuring his right knee. Connell was diagnosed with bursitis and provided with a knee brace. Connell returned to work the day after the accident, continued to meet the physical demands of his job and did not return to the physician for any further treatment.

In August 2006, Connell rammed the same knee into a glass coffee table when he entered a suspect's home to execute a warrant. Connell did not seek medical treatment or miss any work, and he continued to work until May 2007.

In May 2007, Connell was riding a four-wheeler at his home. When he placed his right leg on the ground to stabilize the four-wheeler, it began to tip over causing a sharp pain and a pop in his right knee. He was then diagnosed with tears in his anterior cruciate ligament ("ACL") and in his knee cartilage. Surgery was performed and Connell missed approximately seven weeks of work.

Connell sought workers' compensation benefits for his injury. The parties agreed that Connell injured his right knee at work in March 2005 and August 2006. They denied benefits as not causally connected to his work-related accidents because of the new injury from the four-wheeler incident.

The ALJ found that part of the medical condition was related to his work injury but not all and denied TTD benefits. The Appellate Division denied all benefits. The Superior Court then reinstated the ALJ Award.

The Court of Appeals held that there was evidence to support the Appellate Division's findings that there was a separate and distinct injury caused solely by the four-wheeler incident, rather than by the gradual worsening of his prior knee condition due to the wear and tear of work.

Georgia Coverage

INDEMNIFICATION/DUTY TO DEFEND: Where contractor intentionally failed to conduct criminal background check on trainee who assaulted and killed homeowner, Court held there was no duty to defend or indemnify because death was not result of accident within meaning of coverage provisions of policy.

Rucker v. Columbia Nat. Ins. Co., 2010 WL 4869787 (Ga. App. A10A0935, A10A0936), decided December 1, 2010.

Anthony and Rhonda Rucker contracted with American Home Shield Corporation ("AHS") for AHS to service or replace appliances in their home. To fulfill the contract, AHS retained Jeffrey Taylor d/b/a Pro Tech Appliance Service ("Taylor") to perform appliance repair work at the Ruckers' home.

Taylor maintained a Contractor's Business Owners Policy with Columbia National Insurance Company ("Columbia"), which provided that Columbia would "pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' . . . to which this insurance applies." The policy further stated that the insurance applied to "bodily

injury" only if the "bodily injury" was caused by an "occurrence," which was defined as "an accident" in the provisions.

While working at the Ruckers' home, one of Taylor's trainees entered the home "under color of employment with" Taylor and assaulted and killed Rhonda Rucker and assaulted and kidnapped her son. Taylor had hired the trainee without first conducting a criminal background check, because his usual practice was to run a background check only when he thought he would hire the trainee. If Taylor had run a check on this particular trainee, he would have discovered a history of violent crime, including a plea of guilty to the charge of aggravated assault with intent to rape.

Anthony Rucker and Sarah Farmer (collectively "Rucker") filed an action for wrongful death against the trainee, Taylor, and AHS. With respect to Taylor, Rucker claimed that Taylor was liable because he had hired and retained the trainee without conducting a criminal background check.

Columbia brought a declaratory judgment action asking the court to declare, among other things, that it had no duty to defend or indemnify Taylor or AHS because the "bodily injury" did not result from an "occurrence" within the meaning of the policy provisions. The trial court agreed and granted Columbia's motion for summary judgment.

On appeal, the Court of Appeals affirmed the trial court's ruling on the grounds that Taylor's intention to forego a criminal background check of the trainee was an event that took place with Taylor's foresight, expectation, or design. Finding that an "accident" is an unexpected happening which takes place without one's foresight, expectation, or design, the Court ruled that the "bodily injury" was not caused by an "accident." Consequently, there was no coverage and no duty to defend or indemnify.

INSURANCE LAW/COVERAGE: Mere negotiation for settlement by insurer after expiration of contractual limitation period, without actual settlement, does not waive insurer's contractual limitations defense.

Stone Mountain Collision Center v. General Cas. Co. of Wisconsin, 2010 WL 3516748 (Ga. App. A10A0905), decided September 10, 2010.

Stone Mountain Collision Center (SMCC) purchased a commercial policy from General Casualty Insurance Company of Wisconsin (General Casualty). The policy contained a limitation period, creating a two-year limit of time from the date of loss for an insured to bring an action against the insurer.

SMCC suffered a loss due to theft in November 2005. General Casualty was placed on notice of the loss in January 2006 and a reservation of rights was issued. General Casualty, through an independent adjuster, made a settlement offer to SMCC in November 2006 and continued to negotiate the loss through June 2007, when negotiations stopped with the loss remaining unresolved.

In March 2008 (almost two and a half years after the loss), SMCC's attorney contacted General Casualty. At that time, a General Casualty adjuster reinstated the 2007 offer. Negotiations continued through July 2008.

Ultimately, SMCC rejected General Casualty's July 2008 offer and sent a letter requesting continued negotiations. General Casualty never responded and SMCC filed suit. General Casualty filed a motion for summary judgment on the grounds that the two-year contractual limitation period in the policy barred SMCC's action. The trial court agreed and granted summary judgment in favor of General Casualty. SMCC appealed, arguing that an issue of fact existed as to whether General Casualty's actions in negotiating the loss after the expiration of the limitation period waived General Casualty's right to rely on the limitation period.

The Georgia Court of Appeals affirmed judgment in favor of General Casualty, distinguishing the Auto-Owners v. Ogden, 275

Ga. 565 (2002), case relied on by SMCC. In Ogden, the Georgia Supreme Court ruled that if an insurer does not deny liability and negotiates a loss with the insured such that the insured may be lulled into the belief that a limitation clause is waived, whether this would constitute a waiver of the limitation may be a question of fact for the jury.

Here, the Court of Appeals distinguished Ogden, indicating the negotiations between SMCC and General Casualty were still ongoing at the time of the expiration of the limitations period. In contrast, the claimant in Ogden thought he had resolved his claim with the insurer in its entirety prior to the expiration of the limitation period and that final payment would be forthcoming pending receipt of a final proof of loss.

The Court of Appeals further found that the actions of the General Casualty adjuster after the expiration of the limitations period did not waive the limitation clause because a claims adjuster is not authorized to waive a contractual limitation period without express authority from the insurance company and there was no evidence presented that such authority existed.

INSURANCE LAW/COVERAGE/LIMITATION OF LIABILITY: Under "second permittee doctrine," when third person uses insured vehicle via another person who was authorized by owner to use vehicle, third person's use must be with permission or with reasonable belief he is entitled to use vehicle.

Clayton v. Southern General Ins. Co., 306 Ga. App. 394, 702 S.E.2d 446 (2010).

Jocorey Dillard and Lakesha Robinson suffered injuries in an auto accident when their vehicle was struck by a vehicle insured by Southern General Insurance Company (SGIC). SGIC filed a declaratory judgment action seeking a ruling that its policy excluded liability coverage for the driver of its insured vehicle. The trial court granted summary judgment in favor of SGIC. Dillard, Robinson and Patricia Clayton (a friend of Dillard) appealed, contending there was a genuine issue of material fact as to whether the driver of the insured's vehicle was covered as a permissive user under SGIC's policy.

On May 24, 2008, Latoya Wooten asked her mother, Gynetha, if she could borrow Gynetha's car to drive home. In the past, Gynetha had allowed Latoya to borrow her car for limited purposes such as picking up groceries, but had always maintained that no one else could drive the car and that Latoya was required to return it immediately after her errands. Latoya did not have her own set of keys to the car. On this occasion, Gynetha permitted Latoya to use the car, but told her that she could only drive it home and then to work the next morning, at which time Gynetha would come to retrieve it.

Latoya drove the car home that afternoon. Later that evening after Latoya went to bed, Wayne Neal, Latoya's boyfriend, took the keys to the car and drove to pick up his cousin to go to a nightclub. On the way back from the nightclub, Neal's cousin was driving the car when it collided with a vehicle in which Dillard and Robinson were passengers. Latoya was not aware that Neal had taken the car until the next morning when she found out about the accident.

In affirming the trial court's grant of summary judgment in favor of SGIC, the Court of Appeals held that because neither Gynetha nor her daughter was driving the vehicle at the time of the accident, the relevant question for determining coverage was whether the owner or the one in legal possession of the vehicle gave the driver permission to use it. The Court found there was no evidence suggesting that Gynetha or Latoya gave either Neal or his cousin permission to operate the vehicle. To the contrary, the evidence showed that Gynetha told Latoya that no one else had permission to use the car and that even Latoya's use was limited to driving home and to work. Therefore, there was no genuine issue of material fact.

The Court further found that coverage was expressly excluded under the policy, given that Neal and his cousin were not using the car with a reasonable belief they were entitled to do so. The Court reasoned that, "unlike spouses who have exchanged keys to their respective

cars, friends who have not done so cannot reasonably be presumed to have dispensed with the necessity for securing express permission prior to driving each other's automobiles." Although Latoya and Neal were more than friends and had a child together, they were not living together and Neal was never given a set of keys to the car, so there was no genuine issue of material fact.

Finally, the Court stated that SGIC would still have been entitled to summary judgment because the "second permittee" doctrine provides that "when a third person uses a car via another person who did have permission to use the car, this is a permissive use under the insurance policy as long as the use falls within the scope of the permission." To determine whether use falls with the scope of permission, the test is: (1) whether the owner's permission to the first permittee included the use to which the third person put the car and (2) whether the scope of the permission the third person received from the first permittee exceeded the scope of permission given the first permittee by the owner. Here, Neal and his cousin's use far exceeded the permission given by Gynetha to Latoya, thus the trial court's decision was affirmed.

INSURANCE LAW/LIMITATION OF LIABILITY: Car dealership's insurance coverage is governed by O.C.G.A. § 33-34-3(d) when dealership provides car for customer's use without rental fee. Policy provisions still govern whether customer is considered insured and amount of coverage available to customer.

Grange Mut. Cas. Co. v. Fulcher, 306 Ga. App. 109, 701 S.E.2d 547 (2010).

Tony Fulcher filed a declaratory judgment action against Grange Mutual Casualty Company, Stacy Marquell Riden, David Trapp, and David Trapp Sales, LLC ("Trapp"). Fulcher was involved in an accident with Riden, who was driving a vehicle owned by Trapp. Trapp was insured by Grange Mutual under a Garage Auto Policy for the business of used car sales.

Riden purchased a 1990 Geo Prism from Trapp and made weekly payments of $50. Two months after taking possession of the Geo, she returned to Trapp because her car was not working properly. Trapp told her that the Geo needed a new transmission and that they would try to repair the car.

While visiting Trapp to make her weekly payment on the Geo, Trapp loaned Riden a 1993 Nissan coupe while Trapp repaired her car. While Riden was driving the Nissan, she collided with a motorcycle driven by Fulcher. Riden had no insurance at the time of the accident because her personal auto policy was cancelled two months earlier. Fulcher filed suit.

Fulcher and Grange Mutual filed cross motions for summary judgment. Fulcher argued that the Grange Mutual policy provided $300K of coverage for the injuries he sustained in the accident, and Grange Mutual contended that, at most, the policy provided coverage in the amount of $25K, Georgia's compulsory statutory minimum limit. The trial court agreed with Fulcher. Relying on A. Atlanta Autosave v. Generali-U.S. Branch, 270 Ga. 757 (1999), the court reasoned that Trapp was acting as a U-drive-it agency when it loaned the car to Riden. The trial court concluded that public policy dictated that Fulcher was entitled to the full amount of coverage of $300K. Grange Mutual appealed and the Court of Appeals reversed, holding that Riden was an insured under the policy provisions, but only up to the compulsory legal limit.

The Court distinguished A. Atlanta Autosave on the grounds that that case involved the issue of priority of liability coverage between a vehicle renter's insurance carrier and that of the rental agency. A. Atlanta Autosave was thus governed by O.C.G.A. § 40-9-102, which dictates the insurance requirements of U-drive-it agencies.

In this case, Trapp was not a U-drive-it agency but instead a car dealership as defined by O.C.G.A. § 43-47-2(17)(a). As such, Trapp's liability insurance requirements for used and new motor vehicle dealers were outlined in O.C.G.A. § 33-34-3(d), which addresses the priority of liability coverage as between the insurer of the owner of the car and that of the nonowner/nonemployee driver of the vehicle. The Court reasoned that, although this case did not involve priority of coverage between two

different insurance policies (since Riden had no personal coverage), its holding was in line with the intent of the statute. Essentially, Grange Mutual provided the primary coverage because Riden was uninsured, *but* its policy provisions governed, unambiguously providing that Riden, as a customer, was considered an insured, up to the compulsory legal limits. Had Trapp's policy provided no coverage whatsoever because the customer was not an employee of the owner, or had it limited the coverage to an amount less than the compulsory limits, such restrictions would have violated public policy. *See* Hendrix v. Universal Underwriter Ins. Co., 263 Ga. App 589 (2003).

Florida Liability

DAMAGES/COLLATERAL SOURCE: Plaintiff may introduce as evidence to jury plaintiff's gross medical expenses or bills in lieu of discounted amount actually paid by private health insurer under collateral source rule.

Nationwide Mutual Ins. Co. v. Harrell, 35 Fla. L. Weekly D2873, ---So.3d--- (Fla. 1st DCA 2010).

Nationwide appealed a judgment entered against it in an action by its insured for uninsured motorist coverage. During the trial, the plaintiff/insured introduced evidence and requested damages from the jury in the gross amount of her medical bills, not the lesser amount actually paid by the plaintiff's private health insurer for settlement of the medical bills.

Nationwide claimed it was error for the court to permit the insured to introduce into evidence the gross amount of her medical bills because it misled the jury as to the true amount of her actual damages. The collateral source rule prohibits the introduction of evidence of payments from collateral sources when an objection is raised. The Florida Supreme Court has held that "discounts" negotiated by a plaintiff's private health insurer with healthcare providers constitute a collateral source for purposes of setoff against a total award of damages (pursuant to section 768.76(1), Florida Statutes). Given that such discounts are considered a collateral source for setoff purposes, the Court noted, such payments would also constitute a collateral source for purposes of the evidentiary rule on inadmissibility of a collateral source. Thus, evidence of the collateral source and how much was paid is inadmissible.

The Court rejected Nationwide's arguments, noting that all of the cases relied upon by Nationwide (holding that it was error to permit a plaintiff to introduce evidence of the gross amount of medical bills) involved payments by Medicare, not a private health insurer. The Court pointed out that the Florida Supreme Court has specifically held that evidence of governmental or charitable benefits are not precluded by the collateral source rule. Thus, Medicare or public benefits are an exception to the general rule. However, this exception is clearly limited to cases where the medical benefits were not earned or paid for by the plaintiff, and thus inapplicable to the instant case. Consequently, the trial court did not err in permitting the plaintiff to present evidence of her gross medical bills rather than the amount actually paid.

CIVIL PRACTICE/SANCTIONS: Plaintiffs' lawsuit was properly dismissed for fraud on court where plaintiffs repeatedly and intentionally lied for several years.

Sun v. Aviles, 35 Fla. L. Weekly D2861, ---So.3d--- (Fla. 5th DCA 2010).

Mr. Sun brought a personal injury action when he was allegedly injured in an automobile accident and his wife and daughter joined their loss of consortium claims. During discovery, the defendants learned that the plaintiffs had repeatedly and continuously lied about Mr. Sun's employment and his ability to work and perform daily living activities following the accident. As a sanction for their commission of fraud upon the court, the trial court dismissed the plaintiffs' action with prejudice after the truth regarding the plaintiffs' assertions was discovered. The plaintiffs appealed.

As explained by the Fifth District Court of Appeal, trial courts in Florida have the inherent authority to dismiss an action as a sanction where a plaintiff has perpetrated a fraud on the court. That authority, the Court noted, should be used "cautiously and sparingly" though, and only upon the most blatant showing of fraud, pretense, collusion, or other similar wrong-doing. When seeking the sanction of dismissal of an action, the other party alleging fraud must prove it by clear and convincing evidence. This means that a mere testimonial discrepancy or misstatement is ordinarily not enough; there must be clear evidence of a scheme calculated to evade or mislead the discovery of facts central to the case.

In this case, the Court held that the trial court did not abuse its discretion in dismissing the case and that the plaintiffs' behavior most certainly fit the standard warranting dismissal. The three plaintiffs lied repeatedly over a period of years regarding Mr. Sun's employment and ability to perform daily living activities, lying throughout discovery to their own attorneys and to experts. Plaintiffs admitted that they knew they were supposed to give truthful answers but chose not to.

Although dismissal is a harsh sanction, the Court held that it was definitely warranted under such circumstances where the plaintiffs' conduct made it virtually impossible for the defendant to defend the damage claims pursued by the plaintiffs. While dismissal for fraud on the court is granted sparingly, egregious and repeated misrepresentations by the plaintiff that "hampers the preparation of the defense" may give a defendant grounds for moving to dismiss the action based on fraud.

SETTLEMENTS/PROPOSAL FOR SETTLEMENT: Proposal for settlement directed jointly to more than one party is invalid where it fails to apportion and state amount attributable to each party particularly, even if one party's alleged liability is only vicarious.

Joseph, M.D. v. Niosi, 35 Fla. L. Weekly D2773, 50 So.3d 698 (Fla. 1st DCA 2010).

In an action for medical malpractice, Plaintiff Lynn Niosi and her husband sued a physician and a medical practice corporate defendant. During the action, the plaintiffs served three different proposals for settlement to the defendants, who effectively rejected each proposal by failing to accept any of them within the 30 days provided for under Fla. R. Civ. P. 1.442(F). Following a trial, the jury returned a verdict in the plaintiffs' favor awarding them $510,175.

The plaintiffs then filed a motion for attorneys' fees under the proposal for settlement statute. While the first proposal for settlement was found unenforceable by the trial court for reasons not explained by the Court of Appeal, the Court found Mrs. Niosi's second proposal for settlement to the medical practice (upon vicarious liability) of $239,999 as to Count II of the amended complaint enforceable. Mr. Niosi also served a proposal for settlement to both Dr. Joseph and the corporate defendant for $19,999 for his consortium claim which was Count III of the amended complaint. The trial court awarded

the plaintiffs attorneys' fees after the verdict for each was returned in favor of Mrs. Niosi and Mr. Niosi for at least 25% more than the proposal amount pursuant to Fla. Stat. § 768.79(6)(b).

On appeal, the First District Court of Appeal noted the current law regarding joint proposals requiring apportionment. Pointing to the recent Florida Supreme Court decision, Attorneys' Title Ins. Fund, Inc. v. Gorka, 36 So. 3d 646, 650 (Fla. 2010), the Court held it was clear that any joint offer must state the amount and terms attributable to each party and include any relevant conditions with particularity. This has been held true, it noted, even when the liability of one party is based on vicarious or derivative liability. Since the proposals at issue failed to comply with this requirement, the Court held they were unenforceable.

The Court affirmed the judgment of the lower court but reversed the award of attorneys' fees based on the facially invalid proposals for settlement. Notably, while the Court applied the current law up to the date of its opinion, the Court pointed to the "rigidity" of the state of that law and explained how the Florida Supreme Court has recently amended Rule 1.442(c) on this issue. Effective January 1, 2011, when a party is alleged to be only vicariously, constructively, derivatively, or technically liable, a joint proposal made by or served on that party need not outline the apportionment or contribution directed to that party. The amendment was not yet effective as of the ruling in this case, but will no doubt have an impact on future decisions as it changes one aspect that courts and parties have struggled with in application of the proposal rule.

Florida Workers' Compensation

APPOINTMENT OF EXPERT MEDICAL ADVISORS: When conflict in medical opinions exists, even if opinions are generated by physicians in different medical specialties, appointment of Expert Medical Advisor is required when physicians providing those opinions are competent to provide same.

AA Gutter Cleaning, Inc. v. Cesario, 35 Fla. L. Weekly D2102, 49 So.3d 281 (Fla. 1st DCA 2010).

In this workers' compensation case, the Employer/Carrier (E/C) requested the appointment of an Expert Medical Advisor (EMA) due to a conflict in medical opinions between an orthopedic physician and a pain management physician regarding whether or not the claimant's industrial accident remained the major contributing cause (MCC) of his low back condition and resulting medical treatment. The Judge of Compensation Claims (JCC) denied the E/C's request and held that Florida Statute Section 440.13(9)(2004) does not require appointment of an EMA unless the medical dispute exists between two doctors within the same specialty.

The First District Court of Appeal held that the statute at issue discusses a "disagreement in the opinions of the health care providers." The Court further stated that it is not uncommon for a claimant's condition to require treatment with multiple health care providers in different areas of specialization. In such cases, the physicians may be competent to comment on the same issue (in this case, causation). In such circumstances, although the different opinions have been provided by physicians in different specialties, they are nonetheless sufficient to establish the need for appointment of an EMA.

Ultimately, the Court reversed the JCC's denial of the motion and remanded the case to the JCC for determination of whether or not a disagreement exists between the providers.

ADVANCES TO CLAIMANT: Advance of no more than $2,000 must be awarded, even in controverted claims, as long as claimant can establish failure to return to equivalent employment earning substantially same wage or has suffered substantial loss of earning capacity or physical impairment, actual or apparent.

Lopez v. Allied Aerofoam/Specialty Risk Services, 35 Fla. L. Weekly D2293, 48 So.3d 888 (Fla. 1st DCA 2010).

Importantly, this case involves a claim that was denied in its entirety from the outset. The claimant requested an advance of $2,000 but the JCC denied the request. Although the JCC determined that an apparent impairment was established, she denied the requested advance on the basis that such an advance could only be awarded on a compensable claim. The JCC asserted that to otherwise require an advance where the claim is completely denied, the E/C would essentially be providing the claimant with a loan without any regard to whether or not the loan could be repaid via recoupment. Thus, the JCC concluded that Florida Statute Section 440.20(12)(c)(2009) did not apply and denied the request for advance.

Florida Statute Section 440.20(12)(c)(2009) permits a JCC to grant approval of an advancement of no more than $2,000 when a claimant establishes at least one of three criteria: "failure to return to the same or equivalent employment with no substantial reduction in wages or has suffered a substantial loss of earning capacity or a physical impairment, actual or apparent…".

The First District Court of Appeal held that nothing within the Florida Workers' Compensation law requires proof that a claimant will actually receive benefits in the future in order to obtain an advance as permitted under Florida Statute Section 440.20(12)(c)(2009). The Court previously dealt with this same issue in Workers of Florida v. Williams, 743 So.2d 609 (Fla. 1st DCA 1999). The Court held then, as it did in this case, that a claimant is not required to show that benefits will be paid to him in the future in order to qualify for an advance under this provision. The Court held that since the legislature did not change Florida Statute Section 440.20(12)(c)(2009) after the Court's prior ruling in Williams, the legislature presumably adopted the Court's interpretation of the statute. Thus, the Court reversed the JCC's denial of the claimant's request for approval of a $2,000 advance.

AUTHORIZATION OF PHYSICIAN BY OPERATION OF LAW: In order to assert that physician should be deemed authorized by operation of law, claimant is not required to establish that authorized treating physician has recommended treatment requested by claimant, denied by carrier and ultimately obtained by claimant on her own.

Romano v. Trinity School for Children, 35 Fla. L. Weekly D2052, 43 So.3d 928 (Fla. 1st DCA 2010).

The claimant sustained multiple orthopedic injuries in an industrial accident. Approximately one year after her accident, she requested psychiatric treatment from the E/C. Her request was denied via facsimile. The claimant then proceeded to obtain treatment on her own from a psychiatrist. After this treatment was initiated, the claimant filed a formal grievance requesting payment of past and future psychiatric treatment. At this point, both parties obtained an independent medical evaluation (IME). The E/C's IME opined that the claimant was suffering from depression and that the major contributing cause of same was the claimant's industrial accident. As a result, the E/C authorized psychiatric treatment, from that point forward, with a psychiatrist of their choice.

The claimant then filed multiple petitions for benefits, seeking reimbursement for past treatment from her own psychiatrist, future treatment with the same psychiatrist and temporary indemnity benefits.

At the trial court level, the claimant argued that under Parodi v. Florida Contracting Co., 16 So.3d 958 (Fla. 1st DCA 2009), the opinions of the physician from whom she received treatment on her own were admissible to support her claim for indemnity benefits. However, the JCC refused to accept the testimony of that physician since he was not an authorized treating physician, independent medical examiner or expert medical advisor. Furthermore, the JCC concluded that since the claimant failed to introduce her actual request for psychiatric treatment into evidence, she had failed to meet her burden of proof under Parodi, although the JCC found that the treatment rendered was reasonable and medically necessary.

On appeal, the First District Court of Appeal examined the prerequisites to authorization of a physician by operation of law and what is required for such physician's opinions to be admissible.

In Parodi, the Court held that a JCC has the statutory authority to retroactively authorize a doctor not explicitly authorized by an E/C when a claimant can establish that he or she (1) made a specific request for care, (2) allowed the E/C a reasonable time to respond and (3) obtained care that was compensable, reasonable, and medically necessary. Once that physician is determined to be authorized by operation of law as outlined above, their opinions are admissible as those of an authorized treating physician.

In this case, the Court ultimately determined that the claimant had met her burden of proof under Parodi because the adjuster testified that she received a request for psychiatric treatment from the claimant, the adjuster sent a fax to the claimant's attorney denying the request and, as noted above, the JCC found that the psychiatric treatment received was reasonable and medically necessary. Accordingly, the JCC erred by excluding testimony from the claimant's own psychiatrist. The JCC's decision was reversed and the case was remanded for further proceedings.

As an aside, it should be noted that this Court also recently clarified that while the above is true, an E/C is free to select a new physician for the claimant to continue to receive care and treatment from once the period of wrongful denial is over (either by voluntary provision of benefits as in this case or by an award determining that continued care and treatment is reasonable and medically necessary). Carmack v. State, Dept. of Agriculture, 31 So.3d 798 (Fla. 1st DCA 2009).

Additionally, this case is particularly important because the Court held that a claimant does not need a referral to support the claimant's request for treatment in order for the treatment to be authorized by operation of law under Parodi.

MISREPRESENTATION: Not all impeachable statements from claimant constitute misrepresentation in pursuit of benefits sufficient to deny benefits. To constitute misrepresentation, claimant must have made false statement with specific intent to enhance claim.

Steel Dynamics Inc. v. Markham, 35 Fla. L. Weekly D2348, 46 So.3d 641 (Fla. 1st DCA 2010).

This case involves an appeal filed by an E/C after an award of benefits based on the JCC's rejection of the E/C's misrepresentation defense.

The claimant sustained a compensable injury to his lower back that ultimately required surgery. After he recovered from the procedure, he returned to work in a light duty capacity. Seven months later, the claimant submitted his written resignation, stating he was resigning due to economic reasons and was going to work for another employer.

As it turns out, the claimant actually earned less at his new job than with his previous employer. His duties at the new job consisted of driving a train short distances while seated, monitoring computer screens and occasionally unfastening bolts with a wrench. Insofar as the latter is concerned, he was provided with assistance, if needed, to unfasten bolts that were

too difficult for him to unfasten on his own. After working for the new employer for approximately one year, he began experiencing an increase in his low back pain and ultimately was terminated because the subsequent employer could not accommodate his work restrictions.

Following the claimant's termination from his subsequent employer, he filed a claim against his previous employer, requesting temporary indemnity benefits. The E/C denied the claim from the outset, asserting that the claimant's initial industrial accident was not the major contributing cause ("MCC") of his disability. The E/C also asserted a misrepresentation defense.

In his deposition, the claimant testified that although he was actually able to work light duty for the employer following his recovery from surgery, he was having difficulty performing the work and the real reason he resigned was difficulty performing his job duties. He further testified that his subsequent job duties were not physically demanding.

At the trial, the E/C asserted that the claimant had misrepresented his reason for leaving his employment and the physical nature of his subsequent employment in an attempt to obtain workers' compensation benefits. Notably, the E/C's MCC defense fell through as none of the physicians who testified, including the E/C's independent medical examiner, supported the E/C's position.

Insofar as the misrepresentation defense was concerned, the JCC accepted the claimant's trial testimony that he actually left his employment because of the physical difficulties he experienced, rather than because of economic reasons as listed in his letter of resignation. The claimant explained that he did this to "keep the door open" for a possible return to work for this employer in the future. Because a reasonable explanation was offered for the discrepancy, the Court found that the claimant lacked the requisite intent to mislead for the purpose of securing workers' compensation benefits. The Court also noted that the statement was made well before the claimant's disability period began.

With respect to the characterization of his subsequent employment, the claimant maintained that it was not very physical and the JCC accepted this description. Essentially, the Court indicated that the claimant did not make a false statement with regard to the nature of his subsequent employment, but was merely providing his perception of the nature of same.

The First District Court of Appeal held that the JCC's determination that the claimant had not committed a misrepresentation sufficient to bar all further benefits was supported by competent substantial evidence, as outlined above, and therefore would not be reversed. A claimant's state of mind is a factual determination and will be affirmed if supported by competent substantial evidence.

North Carolina Workers' Compensation

UNEXPLAINED FALL: When employee falls at work in course of duties, injury is compensable even if cause of fall cannot be determined.

Hedges v. Wake County Public School System, 699 S.E.2d 124 (N.C. App. 2010).

Plaintiff was injured at work when she walked into a workroom at school to make copies of payroll materials and stumbled. Defendants argued that the fall was not an accident as defined by the North Carolina Workers' Compensation Act.

A hearing was held before a Deputy Commissioner who found that the plaintiff sustained a compensable injury by accident arising out of and in the course of her employment with the employer. The Full Commission affirmed the Deputy

Commissioner's decision. The defendants appealed to the Court of Appeals.

The Court of Appeals affirmed the Full Commission's decision. The Court held that for an injury to be compensable under the Workers' Compensation Act, a claimant must prove that: (1) the injury was caused by an accident; (2) the injury was sustained in the course of employment; and (3) the injury arose out of the employment. The Court found there was no dispute as to the second and third prongs, that the plaintiff's injury was sustained in the course of, and arose out of, her employment. The question raised on appeal was whether an unexplained fall will necessarily constitute an 'accident' under the Workers' Compensation Act.

The Industrial Commission made no clear finding that the plaintiff's injury was the result of an unexplained fall and was silent as to the origin or cause of the fall. Since the cause of the fall was unknown or undisclosed, the Court of Appeals applied prior case law unique to unexplained fall cases. The Court found that when a fall is unexplained and the Commission has made no finding that any force or condition independent of the employment caused the fall, an inference arises that the fall arose out of the employment. The Court made a similar inference in this case because the only apparent active force involved in the fall was the employee's exertions in the performance of her duties.

ENFORCEMENT OF MEDIATED SETTLEMENT AGREEMENT: Even if improper provision is severed from mediated settlement agreement, agreement is not enforceable because it failed to include required statement that no rights other than those arising under Workers' Compensation Act are released.

Kee v. Caromont Health, Inc., ---S.E.2d---, 2011 WL 39047 (N.C. App. 2011).

Plaintiff was a certified nursing assistant for the defendant. In January 2008, she injured her back turning a patient. Plaintiff worked in a light-duty position until she was taken completely out of work by her doctor in June 2008.

In September 2008, the parties participated in a mediated settlement conference. Defendants offered two options: (1) defendants would either accept the claim as compensable and have plaintiff return to her light-duty job or (2) they would pay the plaintiff a lump sum settlement that required her to resign and release her employment rights. Plaintiff agreed to accept the lump sum settlement offer and the parties executed a mediated settlement agreement.

In the settlement agreement, defendants agreed to pay plaintiff $20,000 and, in return, plaintiff agreed to execute a standard compromise settlement agreement. In addition, defendants agreed to pay the costs of the mediation and plaintiff agreed to pay all of her medical expenses. Finally, the settlement agreement stated that plaintiff "will resign and execute an employment release with her share of the mediation costs being consideration."

After the mediation, defendants prepared the settlement documents. However, plaintiff refused to sign them and defendants filed a request with the Industrial Commission seeking to enforce the mediated settlement agreement.

Following the hearing, the Deputy Commissioner entered an opinion and award approving the settlement agreement. Plaintiff appealed to the Full Commission. The Full Commission held that the settlement agreement failed to comply with both statutory requirements (prohibiting the resignation and employment release provision) and Industrial Commission Rules (requiring the inclusion of certain limiting language in the agreement) and therefore refused to enforce the agreement. Defendants appealed to the Court of Appeals and argued that the Commission should have severed the resignation and release portion of the agreement, thereby rendering the remainder of the agreement compliant.

The Court of Appeals upheld the Full Commission's decision and refused to enforce the settlement agreement. The Court found that the Commission's Rules governing compromised settlement agreements state that the agreement

must contain language stating that no rights other than those arising from the provisions of the Workers' Compensation Act are released. In this case, the Court noted that the Commission found that the agreement was not enforceable because it did not contain the required language.

Defendants argued that the offending portion of the agreement was severable from the agreement as a whole and that the Commission could still enforce those provisions over which it had jurisdiction under general contract principles allowing unenforceable provisions to be severed from those which are enforceable. The Court found that the severability principle was not material to this case because the Rules required the agreement to contain certain language and the required language did not appear anywhere in the agreement. Consequently, the Settlement Agreement would not comply with the Rules even if the resignation and release were severed from the rest of the agreement.

EVIDENCE: Where plaintiff's psychiatric evaluation and FCE did not constitute newly discovered evidence, Industrial Commission did not abuse its discretion in denying plaintiff's motion for relief.

Brinn v. Weyerhaeuser Co., ---S.E.2d---, 2011 WL 31436 (N.C. App. 2011).

Plaintiff injured his back at work and the parties entered into a consent agreement requiring plaintiff to cooperate with vocational rehabilitation efforts and to follow the work restrictions recommended by the treating physician. The Deputy Commissioner ordered plaintiff to undergo a functional capacity evaluation ("FCE") and to discontinue vocational rehabilitation. The Deputy Commissioner also ordered the defendants to continue to pay disability benefits.

Plaintiff attempted to undergo the FCE; however, during the FCE, he became so upset that he was transported to the emergency room via ambulance. After creating a disturbance there he was administered a saline solution intravenously which he mistook as morphine. Following the administration of the intravenous fluids, he reported feeling better.

The Deputy Commissioner issued an opinion and award finding in favor of the plaintiff. Defendants appealed. The Full Commission reversed and suspended plaintiff's benefits and plaintiff appealed to the Full Commission.

Plaintiff underwent another FCE and, based on the results of the second FCE, he filed a motion for relief. The Commission indicated that it did not have jurisdiction given the appeal to the Court of Appeals but would have denied the motion if it had jurisdiction. Plaintiff appealed to the Court of Appeals arguing that the Full Commission improperly disregarded new evidence.

The Court of Appeals noted that for the moving party to prevail in a motion for new evidence, it must show that: (1) the witness will give newly discovered evidence; (2) it is probably true; (3) it is competent, material and relevant; (4) due diligence has been used, or there has been no laches in procuring the testimony at trial; (5) it is not merely cumulative; (6) it does not tend only to contradict a former witness or to impeach or discredit him; and (7) it is of such a nature as to show that on another trial a different result will probably be reached and that the right will prevail.

The Court held that additional medical evidence does not constitute newly discovered evidence in a workers' compensation case. The Court found that plaintiff could have scheduled another FCE at any time prior to the hearing. The Court found that the Commission did not abuse its discretion by denying plaintiff's motion for relief because the evidence did not constitute newly discovery evidence.

PARSONS PRESUMPTION/MEDICAL-ONLY CLAIM: Where employer agreed to pay claim on medical-only basis and where there was no previous finding or admission of compensability and no agreement as to compensability between parties, the Parsons presumption does not apply.

Gross v. Gene Bennett Co., ---S.E.2d---, 2011 WL 135646 (N.C. App. 2011).

Plaintiff fell 10-to-12 feet through a ceiling, hitting a concrete floor while working for the defendant. He was treated and ultimately released to return to full-duty work. Defendants accepted plaintiff's claim on a medical-only basis. Plaintiff later sought further treatment and two MRIs showed degenerative disk disease in plaintiff's lumbar spine. The Industrial Commission found that plaintiff's lower back condition was a compensable progression from injuries sustained in the plaintiff's fall and awarded him temporary total disability benefits until he was able to return to work. The Industrial Commission also ordered payment for medical treatment for the lower back condition. Defendants appealed, arguing that the Parsons presumption did not apply to the case.

The "Parsons presumption" holds that where the Commission has made a determination that a worker suffered a compensable injury, there is a presumption that additional medical treatment is causally related to the original injury. The burden of proof then shifts to the defendant to prove that the original finding of compensable injury is unrelated to the present problem.

The Court found that in this case, there was no prior determination of compensability of the plaintiff's injuries either by the Commission, the admission of the employer or agreement of the parties. Thus, the Court held that the presumption could not arise at the initial hearing on compensability before the Commission.

The Court found that the defendants accepted the claim on a medical-only basis and that well-established precedent confirms that the acceptance of a medical-only claim is not an admission of liability.

Defendants also argued that the Commission erred by finding that the disk herniation was caused by the work incident. The Court agreed and found that expert testimony must be based upon expert opinion and that opinion must rise above the level of possibility or speculation. The Court found that the plaintiff's expert opinion in this case did not rise above the level of possibility or speculation. Further, the Court found that the plaintiff's evidence did not support the findings of fact. Thus, the Court reversed the Full Commission's decision.

South Carolina Workers' Compensation

SECOND INJURY FUND/STATUTE OF LIMITATIONS: Ten-year default statute of limitations applies to claims for reimbursement from Second Injury Fund; cause of action for reimbursement accrues from date insurer provides notice to Fund.

Transportation Ins. Co. v. SC Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010).

In 2007, the South Carolina General Assembly passed the Workers' Compensation Reform Act, which provided for the winding down of the South Carolina Second Injury Fund by June 30, 2013.

After passage of the Reform Act, several insurance carriers requested reimbursement from the Fund on claims where more than 10 years had passed since the date of injury. The Fund denied reimbursement based on the 10-year statute of limitations laid out in S.C. Code

Ann. § 15-3-600, which provides: "[a]n action for relief not provided for in this chapter must be commenced within ten years after the cause of action shall have accrued."

The South Carolina Workers' Compensation Commission found the 10-year default statute of limitations did not apply to reimbursement cases. The Fund appealed the decision to the circuit court, but also sought review by the South Carolina Supreme Court while its appeal to the circuit court was pending. The Supreme Court accepted the case for review.

The Court noted that the South Carolina Workers' Compensation Act requires employers and insurers to give notice of a possible claim against the Fund within a specified period of time, but that the plain language of the South Carolina Workers' Compensation Act does not specify a statute of limitations for reimbursement of claims against the Fund.

The Supreme Court also noted that statutes of limitations serve the following important public policy considerations: stimulating activity, punishing negligence, promoting repose, relieving courts of stale claims and giving some kind of end to litigation.

The Supreme Court held that the 10-year default statute of limitations must apply to avoid reimbursement claims extending endlessly into the future so long as the notice requirement was satisfied, thereby thwarting the legislative intent in passing the 10-year default statute of limitations. The Supreme Court also held that a cause of action for reimbursement from the Fund accrues from the date notice is given to the Fund.

COMPUTATION OF BENEFITS: Alternative methods of calculating average weekly wage can only be used by Commission when it finds, or record clearly shows, that necessary conditions exist.

Pilgrim v. Eaton, ---S.C. App. ---, 703 S.E.2d 241 (Decided December 15, 2010).

Danny Pilgrim worked just 29.5 hours before falling from the roof of a garage and injuring his back. The Workers' Compensation Commission set Pilgrim's average weekly wage at $720, multiplying his hourly rate of $18 by a 40-hour work week. The Commission determined $720 to be the reasonable amount Pilgrim would have been earning but for his accident. Both Pilgrim and Eaton appealed the average weekly wage calculation.

The South Carolina Court of Appeals noted that the primary method of average weekly wage calculation (total wages over the four quarters immediately preceding the quarter of injury divided by fifty-two, or actual number of weeks worked, whichever is less) was not permissible in this case because Pilgrim had worked for less than one week at the time of his accident.

The Court then analyzed the available alternative methods of average weekly wage calculation and the conditions that must exist in order for the Commission to make use of each alternative method.

The first alternative method allows average weekly wage to be calculated, if practicable, by dividing total earnings by total weeks (or parts thereof) worked when employment has existed for less than 52 weeks, so long as the results are fair and just to both parties. The Court noted the necessary conditions for this method are that it be practicable, as well as fair and just to both parties. The Court concluded this method was not practicable because an average ideally based on a year's worth of data cannot reasonably be accurate on the basis of 29.5 hours. The Court further concluded this method was not fair and just for the same reason and also based upon Pilgrim's testimony on his prior earnings, which did not support the Commission's calculation.

The second alternative method allows average weekly wage to be calculated using the wages earned by a person of the same grade and character employed in the same class of employment in the same locality or community. The Court noted that neither the parties nor the Commission mentioned this method, so the Court was unable to determine whether it would have been the appropriate method.

The final alternative method allows calculation, where exceptional reasons exist which would make other methods unfair, by such other method which will most nearly approximate the amount the employee would be earning but for the injury. The Court noted that the necessary condition which must be met before this method can be used is that the Commission must make factual findings setting forth the "exceptional reasons" rendering the other methods unfair. Here, the Court found the Commission did not make any findings which supported the use of the "exceptional reasons" alternative.

The Court reversed the Commission's average weekly wage calculation and remanded the case to the Commission to determine whether to allow the presentation of additional evidence or calculate average weekly wage based on evidence already in the record. The Court also directed the Commission to determine the proper method of average weekly wage calculation and make factual findings as to the existence of conditions making the chosen method applicable to the case.

COMPUTATION OF BENEFITS: Commission can prorate lump sum award over employee's life expectancy using life expectancy table provided by state law.

James v. Anne's Inc., 390 S.C. 188, 701 S.E.2d 730 (2010).

Allie James was totally and permanently disabled as a result of a work accident and was awarded a lump sum of compensation benefits. James requested the order include language prorating the lump sum award over her life expectancy using the life expectancy table provided in S.C. Code Ann. § 19-1-150. The hearing commissioner denied the request after the employer and insurer objected, concluding she did not possess the authority to include proration language in the absence of consent from the employer and insurer.

James appealed to the Full Commission, which upheld the hearing commissioner's decision. She then appealed to the circuit court, which affirmed the Commission. James moved for reconsideration, and the circuit court denied that motion.

James next appealed to the Supreme Court of South Carolina. The Court affirmed in a split decision (James v. Anne's Inc., 386 S.C. 326 (2010)), concluding that without an express grant of authority from the General Assembly, the Commission did not have the authority to include proration language absent the consent of all parties. James requested re-hearing and the Court granted her petition.

The Court looked to S.C. Code Ann. § 42-3-180, which states: "All questions arising under this Title, if not settled by agreement of the parties interested therein with the approval of the Commission, shall be determined by the Commission, except as otherwise provided in this Title." The Court found nothing in the South Carolina Workers' Compensation Act, express or implied, which prohibits the proration language at issue in the case.

The Court held the Commission has the authority to prorate a lump sum award over an employee's life expectancy using the life expectancy table provided by South Carolina law, and remanded the case to the Commission to rule on the employee's proration request. The Court also concluded that the Commission's proration of lump sum awards furthers the "humane objectives" of the South Carolina Workers' Compensation Act. Specifically, proration over life expectancy minimizes the reduction of Social Security benefits.

Prior to this decision, employers and insurers were able to use their consent to proration language as a bargaining chip in settlement negotiations with employees already receiving or anticipating an award of Social Security Disability benefits.

EVIDENCE: Employee's claim for permanent disability due to loss of earning capacity denied based on employee's testimony of plans to open his own restaurant.

Hutson v. S.C. State Ports Authority, 390 S.C. 108, 700 S.E.2d 462 (2010).

Franklin Hutson injured his back while working as a crane operator. He reached MMI, was assigned an impairment rating of 10% of the whole person and was issued permanent lifting restrictions of no more than 35 pounds on an occasional basis and 25 pounds on a frequent basis. The treating physician further opined that Hutson should otherwise be able to carry on a moderate level of activity at medium work capacity.

Hutson sought continuation of benefits, asserting he was permanently and totally disabled, because of the effect of the injury on his back and right leg. Before the single commissioner, Hutson, in response to questions about his future plans from his own attorney, testified he wanted to start his own restaurant. Hutson had taken business, culinary and other food-related college courses and his family had long-standing experience in the restaurant industry. Hutson further admitted cooking was not as strenuous as manual labor. He stated he was sure he could run a restaurant and, while he did not know how much money he would earn, he admitted his goal of opening his own restaurant was in an effort to move up to a higher income bracket.

The single commissioner found Hutson failed to prove a loss of earning capacity so as to qualify for compensation under the general disability statutes. Instead, the single commissioner found Hutson had a 30% loss of use to the back and awarded compensation for a scheduled loss.

Hutson moved for reconsideration. The single commissioner held a second hearing, but did not alter the decision. On appeal, the appellate panel affirmed the single commissioner. Hutson then petitioned for judicial review. The court of common pleas affirmed the appellate panel's order.

The case then came before the South Carolina Court of Appeals. Hutson attempted to argue his testimony was the only testimony supporting the finding that he could run a restaurant and that his testimony was speculative in nature. He further argued that the commissioner and appellate panel disregarded the written statement of his vocational consultant, which he alleged was the only expert evidence in the record.

The Court disagreed with Hutson's assertions, noting that his testimony as to his education, experience, research and physical ability to supervise and run the register was not merely speculative. Furthermore, the Court noted that the fact finder may disregard non-medical expert testimony in the same manner that medical testimony may be disregarded when there is other competent evidence in the record. The Court also noted that there was other expert evidence of ability to work in the record from the treating physician, as well as a second opinion from a physician selected by Hutson.

The Court held there was substantial evidence in the record to support the appellate panel's finding that Hutson did not prove a loss of earning capacity that would entitle him to an award of compensation under S.C. Code Ann. § 42-9-20 and that he was limited to scheduled loss benefits for his back under S.C. Code Ann. § 42-9-30.

The case was remanded to the Commission on the issue of potential additional scheduled loss compensation for Hutson's leg.