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LEGAL UPDATE

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The New Frontier: Controlling Medical and Indemnity Benefits with the 2003 Changes to Florida's Workers' Compensation Law.

By Kraig N. Johnson, Esq. & Brian C. Dowling, Esq.

The 2003 changes to Florida's workers' compensation law have produced significant advantages in claims handling and litigation strategies for employers, carriers and servicing agents statewide. This has been due, in large part, to the increased control which an adjuster can exert over ongoing medical care, as well as the scaling back in indemnity entitlement for injured workers and fees for attorneys who represent them.

***Butler* and the Application of the New Law to Old Claims**

Florida's First District Court of Appeal recently had the opportunity to consider the application of the 2003 law changes to an old law case in *Butler v. Bay Center/Chubb Ins. Co.*, 32 Fla. L. Weekly D123 (Fla. App. 1 Dist. Dec 29, 2006). The opinion in *Butler* could potentially have a profound and immediate effect on all existing claims, be they new law or old law.

As detailed in *Butler*, the claimant was injured on September 3, 1986. Her treatment continued on an authorized basis for many years. In April, 2005, the claimant's authorized treating physician recommended a referral for pain management. A Petition for Benefits was filed by the claimant on July 22, 2005, requesting treatment with a specific pain management physician. On August 5, 2005, the employer/carrier authorized and scheduled an appointment for the claimant with a physician different from the one specified by the claimant in the Petition for Benefits. The claimant did not attend the appointment and, instead, requested her one-time change in treating physicians. The claim proceeded to trial on the issues of the timeliness of the authorization and whether the claimant could utilize her one time change without ever attending the initial appointment scheduled by the employer/carrier.

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Interestingly, at the trial the JCC applied the 1986 version of F.S. §440.13 to the facts of the case, and neither the employer/carrier nor the Claimant argued otherwise. Based on same, the JCC found that the appointment was timely set by the E/C and the Claimant did not have a statutory right to a change in physicians without a “reasonable objection” to the physician authorized. The judgment for the E/C was appealed by the Claimant.

On appeal, the Court felt that the timeliness of the appointment was not really in dispute and quickly disposed of the issue without further discussion. However, the Court then went in a completely different direction than the parties, or the JCC for that matter, on the one time change issue. The Court specified that,

“Section 440.13, Florida Statutes (2005), establishes an E/C’s duty to ensure an injured claimant receives medical treatment, and it prescribes the *procedure* for authorizing medical providers...accordingly, the 2005 version of section 440.13, controls in this case.” (emphasis in original)

Applying the current iteration of F.S. §440.13, the Court determined that employer/carrier timely and properly authorized the pain management physician for the claimant and that; consistent with another recent decision on the issue, the claimant could not utilize her one time change without attending the scheduled appointment. In essence the opinion of the JCC was affirmed, but for a reason different from that set forth in the opinion.

However, the implications of the above cited language are almost stunning in their scope, and reach far beyond the relatively simple issue presented on the appeal. A claimant’s access to medical care and treatment is encapsulated almost entirely in F.S. §440.13. In *Butler*, the Court determined that it is the *most recent* version of that statute which governs an employer/carrier’s responsibilities for furnishing medical care, *regardless of the date of accident*. The following are examples of how the holding in *Butler* applies to all claims, regardless of the date of accident. These examples apply, however, only to claims which are not governed by managed care (which has its own rules and applicable statute).

- The Claimant is entitled to one, and only one, IME per claim and that IME must be paid for by the Claimant.
- The employer/carrier get to choose the Claimant’s one time change in treating physicians, provided that the selection is made within 5 days of the written request. The panel of three, from previous versions of the statute, has been eliminated.
- The Expert Medical Advisor (EMA) portion of the statute is applicable, regardless of date of accident.
- The Claimant is limited to 24 visits or 12 weeks of chiropractic treatment, whichever comes first.

Butler presents employer/carriers with significantly increased control over medical benefit entitlement. So long as claims are carefully monitored, the employer/carrier is empowered to direct every aspect of an injured worker’s medical care from initial injury onward,

regardless of the date of accident, unless the injured worker is willing to pay out of pocket for their own IME. This will produce a long term savings in claim costs, as well as allowing employer/carriers to leverage down the value of claims for exposure and settlement purposes.

It should be noted that at the time of this writing, a request has been made that the Florida Supreme Court exercise their discretionary jurisdiction and review the decision of the First District Court of Appeal in *Butler*. It is highly doubtful that the Supreme Court will be willing to do so, as this sort of review is usually only granted in extraordinary circumstances. Also, historically, the Florida Supreme Court has shown a propensity to defer to the First District Court of Appeal on workers' compensation issues, as almost all opinions on workers' compensation appeals come out of that court.

Medical and Indemnity Apportionment

One of the most important developments the legislature took in reducing overall benefit exposure was the institution of medical apportionment in F. S. §440.15 (5)(b) (2003). By virtue of this section, disabilities and medical treatment are only payable to the extent that they are related to a compensable injury, excluding any disabilities or medical conditions which pre-existed the accident. This apportionment exists irrespective of the fact that the preexisting disability or condition may have been asymptomatic or unknown. Mechanically, as set forth in the statute, this is done on a percentage basis with the preexisting condition being apportioned out.

As an example, if a worker sustains a low back injury on the job and the treating physicians determine that 20% of the Claimant's ongoing need for care and treatment is related to preexisting degeneration of the lumbar spine, while 80% is related to the industrial accident, then the employer/carrier are only responsible for 80%. The other 20% is solely the responsibility of the Claimant.

The importance of this medical apportionment cannot be overstated. It had been a long standing precedent in Florida that medical benefits of any type were absolutely not subject to apportionment. The 2003 changes to the statute in this instance were specifically made to reverse that precedent.

Furthermore, F. S. §440.15 (5)(b) (2003) speaks in terms of preexisting 'disability', rather than only preexisting medical conditions. 'Disability' is a much broader term, and is specifically defined by statute. As set forth in F. S. §440.02 (13) (2003) disability is "incapacity because of the injury to earn in the same or any other employment the wages which the employee was receiving at the time of the injury." Said differently, disability in Florida is defined in terms of earning capacity. This, in turn, raises the argument that indemnity entitlement is also apportionable.

Indemnity has always been tied to an injured workers' medical status. A complete medical no-work status potentially gives rise to temporary total disability, and possibly permanent total disability. A return to work with restrictions potentially entitles an injured worker to temporary partial disability or impairment income benefits. Florida has always

recognized that the permanent categories of indemnity benefits, PTD, IIB's, and Wage Loss benefits (the last having been eliminated by the legislature in 1994) were apportionable just as medical benefits are now apportionable. Indeed, this has historically been one of the few ways of leveraging down exposure for permanent total disability. However, the 2003 changes would now seem to give rise to the argument that the *temporary* categories of benefits are also apportionable. If indemnity benefits are tied directly to the underlying medical condition, and the medical condition is now completely apportionable, then ALL categories of indemnity are arguably now apportionable. As discussed above, that apportionment is defined in terms of disability and disability, in turn, is defined in terms of earning capacity.

Taking this argument one step further it could be theorized, with some strong support from the above statutes, that retraining benefits and even death benefits are also apportionable.

Medical apportionment as set forth in F. S. §440.15 (5)(b) (2003) is now a generally accepted principle, and most attorneys who represent injured workers would recognize that an employer/carrier are entitled to reduce that percentage of medical care which has been shown to preexist an industrial accident. The indemnity question, on the other hand, is a much more fertile area for litigation and there have been no opinions entered by any of Florida's District Courts of Appeal, or Supreme Court, on the issue.

So, how do an employer/carrier best avail themselves of the advantages that the new statute provides? One of the most important considerations is physician selection, both from the outset of a claim, and through the entire course of treatment. Not all physicians are created equally and some are more sensitive to the nature of preexisting disability than others. A detailed health questionnaire, physical exam, and close questioning of the injured worker regarding prior injuries and treatment are crucial to establishing the presence of preexisting disability. Needless to say, these questions are also important for another reason, the potential for fraud. Similar care must be taken with referral physicians, one-time changes and, of course, IME's.

Background checks, claims searches, and hospital searches can also provide some warning early in the life of a claim as to whether there has been a history of injury and treatment.

In Florida, physicians are required to conference with any party to the claim, or their agents or attorneys, to discuss the injured worker's condition. This can provide important opportunities to flush out prior injuries, vague records, clarify causes of concern, and obtain favorable medical narratives which set forth specific apportionment percentages. Narratives such as these are an integral part of any effective defense strategy and can significantly leverage down the value of a claim for settlement purposes.

Conclusion

The 2003 changes to Florida's workers' compensation law have presented employer/carriers with a number of new tools to control and mitigate exposure for indemnity and medical benefits. *Butler* provides opportunities for significant cost savings from a medical standpoint, by mandating that all claims are governed by the most recent iterations of F.S. §440.13, which are oriented to the benefit of the employer/carrier. The right to medical

apportionment granted by F. S. §440.15 (5)(b) (2003) provides a direct reduction in exposure for medical benefits by virtue of any preexisting condition, and also potentially reduces exposure for indemnity benefits as well. Used in conjunction with an aggressive and proactive legal defense, these tools will reduce overall exposure on new and old claims and provide greater opportunities for fast and efficient settlement and file closure.

CASE NOTES

Georgia Liability

AUTOMATIC DISMISSAL: O.C.G.A. § 9-2-60 and O.C.G.A. § 9-11-41(e) require the automatic dismissal of any action in which no written order is taken for a period of five years.

Nelson v. Haugabrook et al., 282 Ga. App. 399, 638 S.E.2d 840 (Ga. App.), decided November 15, 2006.

In 1998, Plaintiff Nelson filed suit against Defendants Haugabrook and Nathaniel Haugabrook II, Esq., alleging breach of fiduciary duties, breach of contract, and fraudulent and negligent misrepresentation. On April 27, 2005, at the Defendants' request, the trial court dismissed the case pursuant to O.C.G.A. § 9-2-60 and O.C.G.A. § 9-11-41(e) because no written order had been taken between October 8, 1999 and November 7, 2004, the five-year dormancy period.

In an effort to get around the dismissal, Plaintiff re-filed his Complaint on August 29, 2005. Both O.C.G.A. § 9-2-60 and O.C.G.A. § 9-11-41(e) allow the plaintiff to renew their action within six months following the dismissal of their case for want of prosecution. Those statutes also provide that the statute of limitations for the lawsuit would remain the same with regard to the renewal action as well as the original action.

Defendants asked the court to dismiss the renewal action as well, arguing that Plaintiff failed to file his renewal Complaint within the six months following the automatic dismissal of the original lawsuit. The trial court agreed, stating that no order of any kind was entered by the court between October 8, 1999 and October 8, 2004. That being the case, Defendants would have had to file his renewal Complaint by April 8, 2005, which he did not. Therefore, no renewal of the action was authorized.

On appeal, the Georgia Court of Appeals found that the trial court's decision was correct. First, Plaintiff argued that an October 18, 1999 certificate of immediate appellate review constituted an "order" within the meaning of O.C.G.A. § 9-2-60 and O.C.G.A. § 9-11-41(e). Even assuming that the certificate constituted an order under these statutes, the 1998 lawsuit still would have been automatically dismissed as of October 18, 1999 and Plaintiff still would have failed to file the renewal action within six months of that date.

Second, Plaintiff argued that the Court of Appeals' November 29, 1999 denial of his application for an immediate appeal, which was filed in the trial court on December 1, 1999, constituted an "order" under these statutes, thereby interrupting the five-year dormancy period under the statutes.

The Court of Appeals found that under Georgia law, the filing of the denial could not break the dormancy period. Only if the application for immediate appeal had actually been granted could the dormancy period have been suspended to reflect the appellate review. Further, the Court of Appeals found that Plaintiff also failed to file a notice of appeal within 30 days of the April 27, 2005 order. Therefore, Plaintiff was barred from later challenging either the dismissal of his 1998 action or the trial court's findings in that order.

DRAM SHOP ACT: A bar owner is not liable under Georgia's Dram Shop Act in the absence of evidence of knowledge the patron was intoxicated and that the patron was soon going to be driving a motor vehicle.

Becks v. Pierce, 282 Ga. App. 229, 638 S.E.2d 390 (Ga. App.), decided November 2, 2006.

After consuming alcohol at Jay's Place Sports Bar, Jeffery Fleming fell asleep while driving home, and struck an oncoming vehicle in which

Plaintiff Pierce was a passenger. Fleming had been at Jay's for five to five-and-a-half hours prior to the automobile accident and during that time, he

consumed two or three glasses of vodka and two beers. Fleming admitted that he was under the influence of alcohol at the time of the collision and had a Blood Alcohol Content level of 0.109.

Plaintiff filed suit, and Defendant Becks (who owned the bar) moved for summary judgment alleging that the requirements of the Dram Shop Act, O.C.G.A. §51-1-40(b), precluded Plaintiff's recovery as a matter of law. In relevant part, the Act reads, "[a] person who . . . knowingly sells, furnishes, or serves alcoholic beverages to a person who is in a state of noticeable intoxication, knowing that such person will soon be driving a motor vehicle, may become liable for injury or damage caused by or resulting from the intoxication of such . . . person when the sale, furnishing, or serving is the proximate cause of such injury or damage." The trial court denied the summary judgment motion, but the Court of Appeals accepted Beck's application for interlocutory appeal.

The long standing rule in conjunction with the Dram Shop Act is that it does not require *actual* knowledge. Rather, if a provider of alcohol in the exercise of reasonable care *should* have known *both* that the recipient of the alcohol was noticeably intoxicated *and* that the recipient would be driving

soon, the provider would be deemed to have knowledge of that fact.

The Court's analysis centered on *both* whether or not Fleming was noticeably intoxicated, and whether or not the last person who served Fleming a drink should have known Fleming would be driving soon.

As Defendant did not dispute that a question of fact remained as to whether Fleming was noticeably intoxicated, the Court of Appeals focused only on the second part of the Act. The Court ruled that Plaintiff failed to prove that an issue of fact remained as to whether *the last person to serve* Fleming should have known that he was soon to drive. That holding resulted from the absence of any evidence that Fleming displayed his keys at any time, did anything to indicate that he might be driving, and he was not a regular customer whom they knew would be driving. The analysis focused only on the knowledge of the last person to serve Fleming. The Court found the knowledge of any other bar employee was irrelevant.

Therefore, the Court of Appeals reversed the trial court's ruling and summary judgment was entered for Defendant.

PREMISES LIABILITY/BASIS OF AN OWNER'S SUPERIOR KNOWLEDGE: Without showing substantial similarity, evidence establishing a dangerous condition at one place is generally not permissible to show a dangerous condition at another place owned by the same person.

Dew v. Motel Properties, Inc., 282 Ga. App. 368, 638 S.E.2d 753 (Ga. App.), decided October 5, 2006.

Plaintiff Dew filed suit against Defendant Motel Properties, Inc. for injuries sustained as a result of being bitten by a poisonous spider while staying as a guest at one of Defendant's locations. During the night of his stay, Plaintiff was awakened by a pinching sensation in his forearm; however Plaintiff did not investigate the source of the pinching sensation. The next morning, Plaintiff noticed a large welt with red streaks on his arm. After experiencing increasing amounts of pain, Plaintiff sought medical treatment and was diagnosed with cellulites and blood poisoning. The trial court granted Defendant's Motion for Summary Judgment.

The law in Georgia is well-established that in order to recover for injuries, an invitee must prove that (1) the defendant had actual or constructive knowledge of the hazard, and (2) the plaintiff lacked knowledge of the hazard despite the exercise of ordinary care due to actions or conditions within the

defendant's control. The basis of the owner's liability is the owner's superior knowledge.

The Court of Appeals affirmed the grant of summary judgment. Upon performing a review of the record, the Court of Appeals found Plaintiff presented no evidence that Defendant had knowledge of a spider infestation problem at the specific hotel in which Plaintiff stayed. While Plaintiff presented evidence of spider bites at a different motels owned by Defendant, Plaintiff failed to present evidence that any customer or employee of the motel in which Plaintiff stayed had been bitten by a spider, which may have given Defendant knowledge of the hazard. Conversely, Defendant presented evidence that regular pest control was performed at motel where Plaintiff stayed, and that no pest control problems had been reported at that location prior to Plaintiff's incident. The Court of Appeals also noted Plaintiff's own testimony established that he did not investigate

the cause of the pinch to his arm and thus presented no direct evidence that he was bitten by a venomous spider.

The Court of Appeals found other occurrences could only be considered by the trial

court when the conditions of the other occurrences were substantially similar to those at issue. As Plaintiff could not show a history of insect or spider encounters at the motel location where he stayed, he could not establish Defendant's superior knowledge and therefore could not prove Defendants negligence.

PREMISES LIABILITY/PROXIMATE CAUSE: A plaintiff's failure to show any causal connection between the alleged defect in an owner's premises and the plaintiff's injuries is insufficient to attribute liability to the premises owner.

Sturdivant v. Moore, 2006 WL 3615199 (Ga. App.), decided December 13, 2006.

Plaintiff Sturdivant attended a Fourth of July party at the home of Defendant Moore. Although Plaintiff was a first time guest at Defendant's home, he immediately began swimming and diving into Defendant's pool. Defendant and other partygoers saw Plaintiff repeatedly dive from the diving board into the pool and swim across the pool without distress or difficulty. Some time later in the evening, Plaintiff's body was discovered on the bottom of the pool. He was pulled from the water and transported to the hospital, but he never regained consciousness.

Plaintiff's wife filed suit, and Defendant moved for summary judgment alleging that Plaintiff failed to show any causal connection between the alleged defect in the premises and Moore's death. The trial court granted the summary judgment motion.

Plaintiff argued Defendant was liable for failing to turn on the pool's interior light earlier in the night, thereby making it more difficult to see a person in distress. The trial court granted summary judgment on the ground that Plaintiff had equal or superior knowledge of the conditions in and around

the pool, yet he continued to swim. Under established Georgia law, as a social guest in Defendant's home, Defendant only owed a duty to not injure Plaintiff willfully or wantonly.

The Court of Appeals decided Plaintiff's argument that Defendant's failure to turn on the pool light prevented someone from seeing him in time to rescue was based on assumptions and speculation. Several guests testified that there was still light outside when Plaintiff was found in the pool and no witness testified as to the exact time he was found.

Further, the emergency room doctor testified it was not possible to determine how long Plaintiff remained underwater before suffering permanent injury or death because that time varies depending upon the individual. As a result, the Court of Appeals held that without evidence that the drowning was proximately caused by a defect in the pool, it would be mere speculation to conclude that Defendant's failure to turn on the pool light caused Plaintiff's death. Therefore, the Court affirmed the trial court's grant of summary judgment.

REASONABLE DILIGENCE/SERVICE OF PROCESS/STATUTE OF LIMITATIONS: A timely filed complaint is barred by the statute of limitations if the plaintiff fails to use reasonable diligence to find and serve a defendant after the running of the statute of limitations.

Williams v. Wendland, 2006 WL 371803 (Ga. App.), decided December 19, 2006.

Plaintiff Williams sued Defendant Wendland for injuries sustained in an automobile accident occurring in September 2001. Plaintiff filed her Complaint on July 8, 2003 and the Sheriff's Department was unsuccessful in serving Defendant. On August 6, 2003, Defendant filed a Special Appearance Answer claiming he had not been served with the Complaint. Later that month, a paralegal working for Plaintiff's counsel hired an investigator

who contacted Defendant's mother. Defendant's mother gave the investigator Defendant's work address. Plaintiff forwarded the work address to the Sheriff's Department which unsuccessfully attempted service at the work address.

After learning the Sheriff was unable to serve Defendant at his work address, Plaintiff's investigator again called Defendant's mother who

provided Defendant's brother's address. From October of 2003 until June of 2004, a special process server hired by Plaintiff unsuccessfully attempted to serve Defendant at his brother's address.

On June 15, 2004, Defendant moved to dismiss Plaintiff's Complaint for failure to perfect service. The investigator called Defendant's brother who stated Defendant had moved back home with his mother. The investigator contacted the special process server four times from June 2004 to September 2004 requesting Defendant be served at the mother's home. Finally, on September 15, 2004, almost an entire year after the running of the statute of limitations, Defendant was successfully served at his mother's home. Even so, the trial court dismissed Plaintiff's Complaint agreeing Plaintiff was not diligent in serving Defendant, and therefore, the statute of limitations barred the Complaint. Plaintiff appealed.

The law in Georgia requires that in order to toll the statute of limitations for a timely filed complaint, a plaintiff must act in a reasonable and diligent manner in attempting to perfect service. When the plaintiff has notice that the defendant has not been served, and the statute of limitations has run, the plaintiff must act with the greatest possible diligence to serve the defendant. If a plaintiff fails to use the greatest possible diligence, the complaint is barred by the statute of limitations even though it was timely filed.

After reviewing the record, the Court of Appeals decided there was sufficient evidence where the trial judge, at his discretion, could dismiss the Complaint, because Plaintiff was aware of Defendant's whereabouts on June 22, 2004, but made no effort to serve him with the Complaint until September 15, 2004.

SCOPE OF EMPLOYMENT: Issue as to whether taxi cab driver was working at time he struck pedestrian was proper issue for jury and denial of motion for directed verdict proper.

Decatur's Best Taxi Service, Inc., et al. v. Smith, 639 S.E.2d 482 (Ga. App.), decided November 14, 2006.

On the evening of January 3, 2003, between 6:30 and 7:00 p.m., Plaintiff Smith exited a MARTA bus and attempted to cross the street. Plaintiff crossed a double yellow line while attempting to pass the MARTA bus in the turn lane and was struck by a taxicab driven by Gerald Haynes, an employee of Decatur's Best Taxi Service ("Defendants"). Plaintiff suffered a closed head injury, multiple fractures to both legs and required extensive surgery.

Plaintiff sued Defendants in DeKalb State Court for his injuries. The jury ruled in Plaintiff's favor and awarded him in excess of \$1 million in damages. Defendants appealed.

One of the bases for appeal was Defendant Decatur's Best's contention that Defendant Haynes' trial testimony clearly showed he was off-duty at the time of the accident. If that were the case, Defendant Haynes' acts would have been outside the scope of his employment and liability would not extend to Defendant Decatur's Best. Defendant Decatur's Best argued that this testimony supported its motion for a directed verdict. The trial judge denied Defendant Decatur's Best motion. Defendant Decatur's Best argues appealed.

The Georgia Court of Appeals took notice of the conflicting testimony at trial regarding Defendant Haynes' duty status at the time of the accident. Defendant Haynes testified he did not recall working on January 3rd. However, a dispatcher for the taxi company testified that in fact Defendant Haynes had picked up seven fares on January 3rd, and the last of those was at 5:57 p.m. Defendant Haynes testified that at the time of the accident, he was on the way to a friend's apartment, but could not recall the friend's name or where she lived. The dispatcher testified that nothing in the documentation showed that Defendant Haynes went off-duty after the 5:57 p.m. fare.

The Court of Appeals held that the trial judge correctly determined that the testimony of Defendant Haynes and the dispatcher created a jury question as to whether Defendant Haynes was working at the time of the accident. The denial of a motion for directed verdict will be upheld so long as there is some evidence that supports the verdict. Thus, because of the conflicting testimony concerning whether Defendant Haynes was "on-duty", the Court of Appeals affirmed the denial of Defendant Haynes' Motion for Directed Verdict.

Florida Liability

ARBITRATION: Under the Florida Arbitration Code, a broad agreement to arbitrate includes determining defenses to an otherwise arbitrable claim, including the statute of limitations.

O’Keefe Architects, Inc. v. CED Construction Partners Limited, 944 So.2d 181 (Fla. 2006), decided October 19, 2006

General contractor CED Construction contracted with several architects to build housing projects throughout Florida and the United States. One of those contracts was with O’Keefe Architects. After latent construction and design defects were discovered on the O’Keefe projects, CED made repairs and took an assignment of claims against the architect. CED then demanded arbitration against O’Keefe and several subcontractors for the cost of repairs. O’Keefe objected that several of the claims were barred by the statute of limitations and not subject to arbitration as the contract stated in no event shall a demand for arbitration be made when the matter would be barred by the applicable statute of limitations.

The arbitrators ruled against the architect on the statute of limitations defense and O’Keefe filed a complaint for declaratory relief from the arbitrators’ decision. The trial court agreed the statute defense was subject to arbitration. The Fifth District Court of Appeal reversed the trial court in conflict with *Reuter Recycling of Florida, Inc. v. City of Dania Beach*, 859 So.2d 1271 (Fla. 4th DCA 2003).

The Florida Supreme Court first confirmed this matter was controlled by the Florida Arbitration Code (FAC) rather than the Federal Arbitration Act.

The Supreme Court reiterated that on a motion to compel arbitration, the Court must consider: (1) whether a valid written agreement to arbitrate exists, (2) whether an arbitrable issue exists, and (3) whether the right to arbitration was waived. They suggested when the second point is in question, the Court must look to the intent of the parties as reflected in the contract. The Court reviewed the various District decisions and the revised Uniform Arbitration Act. They found the bulk of opinions supported arbitrator determination of the “gateway” issues.

The Florida Supreme Court acknowledged the U.S. Supreme Court’s suggestion that courts should not assume that the parties “agreed to arbitrate arbitrability”. *First Options of Chicago, Inc. v. Kaplan*, 514 U.S. 938 (1995). However, they found that was controlled by the U.S. Supreme Court’s opinion in *Howsam v. Dean Witter Reynolds, Inc.*, 537 U.S. 79 (2002) which suggested questions of arbitrability do not include “waiver, delay, or a like defense to arbitrability.” Thus the Florida Supreme Court held that under FAC a broad agreement to arbitrate includes the determination a of statute of limitations defense and disapproved the 4th District’s opinion in *Reuter Recycling of Florida, Inc. v. City of Dania Beach*, 859 So.2d 1271 (Fla. 4th DCA 2003).

ATTORNEY’S FEES: A third-party bad faith assignee may obtain a fee multiplier under F.S. 627.428.

Allstate Insurance Company v. Regar, 942 So.2d 969 (Fla. 2nd DCA 2006), decided November 29, 2006.

Regar was injured in a motor vehicle accident with *Weaver*. *Weaver* was covered under a \$25,000 per person Allstate bodily injury liability policy. On 12/31/97, Regar offered to settle for Allstate’s policy limits in return for a release prepared by Regar’s attorney. Allstate requested the proposed release and various medical records. Regar

provided the documents and on January 15, 1998 Allstate tendered the limits with a request that Regar use Allstate’s standard release. Regar responded with a list of objections to Allstate’s standard release. Allstate revised its release and hand delivered it and the check to Regar within the 30 day time limit. Regar stated they would no longer settle for the

policy limits. Allstate subsequently settled the tort suit for \$300,000 and *Weaver* assigned Regar her third-party bad faith claim against Allstate in exchange for Regar's promise not to execute the judgment in the tort suit. Regar sued Allstate for bad faith, the parties settled the claim, and Regar moved for attorney's fees under 627.428, Florida Statutes (2004). The trial court awarded \$220,000 in fees including a 1.75 multiplier.

F.S. 627.428 provides fees to "any named or omnibus insured or the named beneficiary" who prevails in a suit against the insurer. Allstate argued the third-party assignee was not such an individual.

The court began with a review of the insurer's duty of good faith and fair dealing. They

noted a third-party bad faith cause of action is assignable because it arises from a contract. The court then added that fees could be awarded to the insured in the same bad faith suit and to an assignee of an insured's in a coverage dispute. They concluded an assignee of third-party bad faith claims stands in the shoes of the insured and is entitled to all remedies to which the insured would otherwise be entitled, including attorney's fees.

In and aside the court noted with disfavor the increasing number of bad faith claims which could have been simply resolved. In spite of that, the Second District Court went on to find that it is within the trial court's discretion to award a multiplier under F.S. 627.428 to an assignee when there is a risk of non-payment.

BAD FAITH: Insurer's tender of policy limits after a civil remedy notice and initiation of a lawsuit by the insured but before an excess judgment, does not preclude a common law bad faith action.

Macola v. Government Employees Insurance Company, --- So.2d --- (Fla. 2006)-, 31 Fla. L. Weekly S690, decided October 26, 2006.

Quigley negligently caused an automobile accident resulting in personal injuries to Macola. Quigley was insured by GEICO under a \$300,000 BI liability policy. On October 19, 1999 Macola demanded the BI liability limits. On July 11, 2000 Quigley filed a statutory civil remedy notice alleging bad faith failure to settle. Within 60 days GEICO sent the policy limits to Quigley who did not accept the tender. Macola's suit resulted in a verdict of \$1.5 million and Macola filed a third-party bad faith suit against GEICO alleging failure to settle. Quigley filed a similar complaint against GEICO. The trial court granted GEICO's motion for summary judgment on grounds the tender of policy limits cured any statutory third-party bad faith and constituted a full satisfaction of the common law claim.

The Supreme Court began its analysis with the *Boston Old Colony Insurance Company* case and its standard for the insurer's duties. They then reviewed the common law third-party and the statutory first-party bad faith development. They

noted F.S. 624.155 does not preempt common law, or any other, cause of action, though a third-party is not entitled to double recovery by proceeding under both remedies. They reiterated that in a statutory first-party action a tender of policy limits within 60 days of the civil remedy notice cures any violation.

However, they distinguished third-party bad faith actions, stating a tender to the insured while the underlying court action is still pending does not eliminate the insured's exposure to an excess verdict. Thus, the insured in a third-party action would be put in a worse position if the tender extinguished the bad faith cause of action.

Ultimately, the Supreme Court held that an insurer's tender of the policy limits to an insured in response to the filing of a civil remedy notice under F.S. 624.155 by the insured, after the initiation of a lawsuit against the insured but before entry of an excess judgment does not preclude a common law cause of action against the insurer for third-party bad faith.

DISMISSAL: A pending motion does not necessarily preclude dismissal for lack of prosecution.

Patton v. Kera Technology, Inc., --- So.2d --- (Fla. 2006), 31 Fla. L. Weekly S700, decided October 26, 2006

In December 1998 plaintiff filed suit for recovery under a contract and two promissory notes. In May 2001 defendants filed a motion to dismiss

which was heard in July 2001. The parties disagree regarding the outcome of that hearing, but no order was entered and no transcript made. In August 2002

defendants filed a motion to dismiss for lack of prosecution which the court granted on August 22, 2002.

The Florida Supreme Court noted the conflict between the districts regarding whether a pending motion is sufficient to avoid dismissal for lack of prosecution. The court reiterated its two-step process for analysis of a motion to dismiss for lack of prosecution: "First, the defendant must show that there is no record activity for the year preceding the motion. Second, if there was no record activity, the plaintiff has an opportunity to establish good cause why the action should not be dismissed." The

Supreme Court noted Fla. R. Civ. P., 1.420(e) and suggested good cause must be shown in writing five days before the hearing and based on affidavits or deposition testimony showing the record activity which has moved the case forward in the preceding year.

Where there is no such evidence, the motion must be granted as the non-moving party bears the burden of proof. The Florida Supreme Court approved the Fifth District Court of Appeal's opinions and disapproved those of the First and Third District Courts.

MISREPRESENTATIONS/PIP: Misrepresentation by one insured does not support the denial of PIP benefits for an unrelated third party/claimant.

Vasques v. Mercury Casualty Company, --- So.2d ---, (Fla. 5th DCA 2007), 32 Fla. L. Weekly D363, decided February 2, 2007.

Vasques was working on an automobile in Shehata's garage when he suffered a serious injury. As a result Vasques lost his job, incurred surgery bills in excess of \$25,000, and sought PIP benefits under Shehata's Mercury auto policy. During Mercury's investigation, Shehata, and her son gave recorded statements denying any such incident and denying even knowing Vasques. Mercury denied the claim and Vasques filed suit. Two years later, in deposition, Shehata and her son reversed their story, admitted the accident, and suggested they lied to protect themselves from a claim by Vasques. The court granted summary judgment to Mercury based upon the policy language stating: "we may deny coverage of an accident or loss if you or an insured person has concealed or misrepresented any material fact ... in connection with the presentation or settlement of a claim." The parties agreed Vasques made no misrepresentation.

The District Court reviewed the rules of construction suggesting interpretation of ambiguous and limiting policy language must be interpreted in favor of the insured. They went on to suggest that denying coverage to one person because of the misrepresentation by another would lead to an absurd result. They concluded that Florida's "Innocent Insured Doctrine" applied to the case because though Vasques was not, strictly speaking, an insured, he was innocent of any wrong doing. The District Court suggested any other finding would be inconsistent with Florida's PIP Statute, and that their decision was consistent with the recent fraud amendments to subsection 4(g) of F.S. 627.736. Accordingly they reversed the lower court's grant of summary judgment.

PIP: An appellate court may not award attorney's fees to an insured unless the insured prevails on appeal.

Brass & Singer, PA v. United Automobile Insurance Company, 944 So.2d 252 (Fla. 2006), decided November 9, 2006.

The Florida Supreme Court reviewed the Third District Court of Appeal's opinion which was consistent with the Fifth District and conflicted with the Fourth District on the question of whether F.S. 627.428 (2004), authorizes an appellate court to conditionally award appellate attorney's fees to an insured that loses on appeal, on the basis that the

insured may be the prevailing party at the close of litigation.

Section 627.428 is the statutory basis for an award of fees "in the event of an appeal in which the insured or beneficiary prevails". The Fourth District held fees may be awarded even if the insured loses on

appeal, on grounds the insured may ultimately prevail in the litigation. The Third and Fifth Districts denied appellate fees in such a circumstance. The Florida Supreme Court ultimately held that under the plain

language of Section 627.428(1), an appellate court may not award attorney's fees to an insured unless the insured prevails on appeal, and thereby disapproved the Fourth District's opinions.

PUNITIVES: Liability must be determined before entitlement to punitives, and compensatory damages before determination of punitive damages.

Engle, MD v. Liggett Group, Inc. , --- So.2d --- 32 Fla. L. Weekly S1 (Fla. 2006), decided December 21, 2006.

In 1994 the Florida trial court certified a nationwide class action group of smokers. In 1998 the trial was divided into three phases. At the end of phase I the jury determined the defendants were liable to the *Engle* class. In phase IIA, the jury awarded class representatives \$12.7 million in compensatory damages. In phase IIB, the jury awarded the entire class punitive damages in the amount of \$145 billion. In 2000 the trial court entered a final judgment awarding the punitive damages. Thereafter in phase III, the jury was to decide the individual compensatory damages for each class member.

Florida Supreme Court held the State of Florida's tobacco suit did not preempt the *Engle* class's punitive damages claim. They also held an award of compensatory damages is not a prerequisite to a finding of entitlement to punitive damages where there has been a determination of liability.

However, because the reasonableness of punitive damages cannot be determined until compensatory damages have been determined, punitive damages cannot be awarded before compensatory damages.

The Florida Supreme Court also reiterated the United States Supreme Court's test of excessiveness for punitive damages. The U.S. Supreme Court rejected a bright line test, but suggested that few awards exceed a single digit ratio between punitive and compensatory damages without violating due process. They also made reference to a 4 to 1 ratio as a guideline. In light of that analysis, the court reversed the punitive damages award, which in this case was 145 times the compensatory damages.

Ultimately, the Florida Supreme Court determined that continued class certification was not possible, though some of the previous class action rulings would stand.

**Georgia
Workers'
Compensation**

COURSE AND SCOPE: An injury arises out of certain employment when it results from exposure occasioned by the nature of employment, or where there is a causal connection between the conditions under which the work is required to be performed and the resulting injury.

Stevenson v. Ray, 2006 WL 343769 (Ga. App.), decided November 30, 2006.

On November 8, 2002, Timothy Ray was employed by the Laurens County Sheriff's Department as a deputy sheriff. After his shift ended, Ray left work in a marked patrol car and wearing his uniform. Ray was on-call that evening, even though he had left work, because he had a "take home"

patrol car. As he was driving home, Ray heard over the police radio that other Laurens County Sheriff's deputies were engaged in a pursuit. Ray radioed the shift supervisor to see if he should join the pursuit. The shift supervisor told him not to respond that the other officers could handle it and Ray was to go

home. After this call, a patrol car responding to the pursuit passed Ray, and Ray decided to activate his emergency siren and lights and follow the patrol car in order to back up his fellow officers. Shortly thereafter, Ray's car collided with a patrol car operated by another deputy sheriff, Barrett Carlos Stevenson.

Barrett Carlos Stevenson and Lisa R. Stevenson, his wife, sued Timothy Ray, Stevenson's co-worker, stating claims for personal injury and loss of consortium. Ray moved for summary judgment on the grounds that the Stevenson's claims were barred by the exclusivity clause of the Workers' Compensation Act, OCGA §34-9-11(a).

Under OCGA §34-9-11(a), "the Georgia Workers' Compensation Act is now the exclusive remedy for injuries sustained by an employee during the course of employment resulting from the negligence of a co-worker [. . .] if, however, the injury was not caused by an accident arising out of and in the course of employment, then the Workers' Compensation Act provides no remedy and the exclusivity provision does not apply." The question for the court was whether Ray was acting in the course of his employment when he joined the Sheriff Department's pursuit.

The Stevensons argued that because Ray was off-duty and had been advised by the shift supervisor not to respond to the incident, the collision between Stevenson and Ray did not arise out of and in the course of Ray's employment, and thus, his claims were not precluded by the Workers' Compensation Act. The Court of Appeals disagreed.

An injury arises in the course of the employment if, at the time of the injury, the employee is involved in that employment. In general, collisions occurring while employees are traveling to and from work do not arise out of and in the course of employment. However, police officers are considered to act within the course of their employment when they are "on duty or on call, that is, subject to duty, because they are often called to enforce the law within their jurisdiction, regardless of whether or not they are actually on-duty at the time. The Court of Appeals found that although Ray was off-duty at the time of the collision, he was on call. Accordingly, Ray was in the course of his employment at the time of Stevenson's injury.

At the time of the collision, Ray was in uniform and had activated the emergency light and siren in his patrol car. More importantly, he was responding to a law enforcement situation, thereby providing a benefit to the Sheriff's department. The collision would not have occurred but for Ray's decision to assist his fellow officers. Therefore, the Court of Appeals found that because there was a causal connection between Ray's employment and the collision, Stevenson's injuries arose out of his and Ray's employment as police officers.

The Court of Appeals found that the trial court did not err in granting Ray's motion for summary judgment and that the Stevensons' claims were barred under OCGA § 34-9-11(a). Stevenson's exclusive remedy for his injuries, which he suffered during the course of employment because of the negligence of a co-worker, are those remedies awarded under the Georgia Workers' Compensation Act.

FARM LABORERS EXEMPT FROM WORKERS' COMPENSATION ACT: An alligator breeding and slaughtering house does not fall under the category of a farm, thus the employer does not fall within this exemption provided in the Workers' Compensation Act.

Cook v. Prehistoric Ponds, Inc., 2006 WL 3627881, decided December 14, 2006.

Claimant alleged that he was bit by an alligator while working for the Employer. Employer is in the business of breeding, rearing, and slaughtering alligators. The slaughtered alligators are then processed for the meats, hides, and heads to be sold. The Claimant's responsibilities included mixing feed, feeding the alligators, and slaughtering. After the injury, the Claimant applied for workers' compensation benefits.

The Administrative Law Judge ("ALJ") found the Employer's business to be a farm and the Claimant to be a farm laborer. The Workers' Compensation Act includes an exemption for farm laborers, as stated in O.C.G.A. § 34-9-2(a). Therefore, the court held that the Claimant was precluded from collecting benefits.

The Claimant appealed the decision to the appellate division of the State Board of Workers' Compensation ("Board"). The Board determined that

because the Employer ran a processing plant, rather than a farm, the Claimant was not a farm laborer, and should receive workers' compensation benefits.

The Superior Court determined that the Employer had a farm, and the Claimant was a non-covered farm laborer. The Claimant appealed the decision to the Court of Appeals. The Court followed prior

decisions that addressed captive alligators, and determined that the Employer was not a farm. Alligators are to be considered wildlife, and not livestock or fur-bearing animals. Thus, the Employer does not fall within the exemption provided by O.C.G.A. § 34-9-2(a) for farm laborers, and the Claimant should receive benefits under the Workers' Compensation Act.

NOTICE TO CONTROVERT: An invalid notice to controvert does not preclude an employer from asserting a change of condition argument.

Fallin v. Merritt Maintenance and Welding, Inc., 2007 WL 121554, decided January 19, 2007.

Claimant sustained compensable injuries to his back on November 13, 1998. On December 17, 1998 TTD benefits were commenced, but the insurer did not pay a 15% late penalty on the benefits. TTD benefits were continued until February 1, 1999 when claimant's TTD benefits were suspended and a Notice to Controvert was filed alleging that claimant had undergone a change in condition for the better.

A hearing was held before an ALJ and the judge found that the employer's failure to pay the late penalty called for by O.C.G.A. §34-9-221(e) rendered the notice to controvert invalid pursuant to O.C.G.A. §34-9-221(h) and further barred the employer and insurer from contesting the validity of the claim. However, the ALJ found that the untimely controvert did not preclude employer and insurer

from raising a change of condition defense. The ALJ further found that claimant had undergone a change in condition as of November 1, 1999 and that any remaining disability was not the result of his work injury.

The ALJ's Award was affirmed by both the Full Board and the Superior Court of Dougherty County.

The Court of Appeals also affirmed. The Court held that while a failure to timely pay benefits precludes an employer or insurer from subsequently denying the claim in its entirety, they remain entitled to raise a change of condition defense pursuant to O.C.G.A. §34-9-221(i).

PTD BURDEN OF PROOF: A claimant must affirmatively show that they are unable to perform any work available in substantial numbers within national economy to qualify for catastrophic designation.

Reid v. Georgia Building Authority et al, 2007 WL 289277, decided February 2, 2007.

Claimant filed a request for catastrophic designation with the State Board alleging that there were not jobs available in substantial numbers in the national economy for which she was otherwise qualified. A hearing before an ALJ was conducted and the judge found that claimant qualified for a catastrophic designation. The Appellate Division of the State Board upheld the ALJ's Award, but the Superior Court reversed the Board's decision.

In so ruling the Superior Court found that the claimant did not present any evidence at the hearing that there were not jobs available within substantial numbers in the national economy for which she was otherwise qualified.

The Court of Appeals affirmed the Superior Court's ruling. The Court of Appeals held that the claimant must present *some* competent evidence that she is unable to perform any work available in substantial numbers in the national economy. The Court noted that the claimant's testimony that she had looked for work was insufficient to carry her burden.

The Court openly criticized the Board for determining that the claimant qualified for a catastrophic designation based on "its own experience." The Court noted that while claimant may in fact qualify for a catastrophic designation, she did not prove that she did, and therefore the Board's decision was improper.

STATUTE OF LIMITATION: The statute of limitation contained in OCGA §34-9-221(h) is inapplicable to and should not reach controversy between two insurance companies, where compensability of the Claimant's injury goes unchallenged, and the sole issue is which insurance company is responsible for paying income benefits.

TIG Specialty Insurance Co. v. Dust-Away, Inc. et al., 2007 WL 333101(Ga. App.), decided February 6, 2007.

In December 2000, the Claimant suffered a compensable work injury while working for his Employer. The Claimant missed no work due to his injuries. At the time of the injury, TIG Specialty Insurance Company (TIG) provided workers' compensation insurance coverage for Employer. Since February 2002, however, Zenith Insurance Company has assumed coverage. In May 2002, the Claimant became unable to work for the first time following his December 2000 accident.

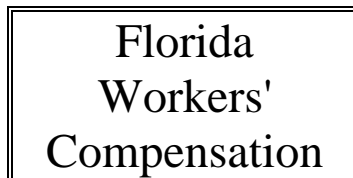
Despite the fact that it no longer insured the Employer, TIG began providing the Claimant with temporary total disability income benefits. In 2004, TIG requested a hearing to decide whether Zenith should reimburse it for payments made following the effective date of the Zenith insurance policy. Zenith and the Claimant filed motions to dismiss TIG's request for a hearing. The Appellate Division of the State Board of Workers' Compensation (the Board) found that TIG's request for a hearing was untimely, and therefore barred by OCGA §34-9-221(h).

The Board and trial court found that TIG was unable to challenge payment in 2004 because of a 60-day statute of limitation contained in OCGA §34-9-221(h), which provides that: "where compensation is being paid without an award, the

right to compensation shall not be controverted except on the grounds of a change in condition or newly discovered evidence, unless notice to controvert is filed with the board within 60 days of the due date of first payment of compensation."

In *Columbus Intermediate Care Home v. Johnston* (196 Ga. App. 516, 396 S.E. 2d 268 (1990)), the Court of Appeals held that the 60-day statute of limitation of OCGA §34-9-221(h) is inapplicable to and should not reach a controversy between two insurance companies where the compensability of the Claimant's injury goes unchallenged. TIG does not challenge the Claimant's right to compensation but only claims that Zenith should be responsible for the income benefits.

The Court of Appeals disagreed with the Board's finding that TIG's request for a hearing put the Claimant's continued right to compensation in jeopardy, and finds that the trial court erred in dismissing TIG's request for a hearing. The Court of Appeals remanded the case to an Administrative Law Judge for a hearing to determine whether TIG or Zenith should be responsible for providing the Claimant with temporary total disability income benefits.



ATTORNEY'S FEES: The only attorney's fee that requires approval from the JCC when a claim has been settled with a represented claimant is the attorney's fee that is to be paid by the claimant.

Rodriguez v. Graduate Plastics, Inc., 31 Fla. L. Weekly D3167b, decided December 18, 2006.

The parties in the case agreed to resolve the claim at mediation for \$9,000.00, of which the claimant would pay his attorney a fee of \$1,600.00. Additionally, the E/C agreed to pay an additional \$4,000.00 attorney's fee to the claimant's attorney.

The claimant failed to execute the documents and the E/C filed a motion to enforce. The JCC determined that the parties had entered into a valid and enforceable settlement agreement. Thus, the JCC entered an order approving the \$1,600.00. The order

did not address the \$4,000.00 attorney's fee. The claimant appealed, asserting that the JCC erred by not including language as to the \$4,000.00 attorney's fee in the order.

On appeal, the Court held that when a claimant settles a worker's compensation case while being represented by counsel, the JCC is only required to approve the attorney's fee to be paid to the claimant's attorney by the claimant pursuant to Section 440.20(11)(c)(2006).

Although the Court determined that the E/C clearly agreed to pay the claimant's attorney a

\$4,000.00 attorney's fee, the JCC did not err in failing to include language approving same in the order. As such, the lower court was affirmed.

This ruling may result in claimant's attorneys seeking E/C paid attorney's fees, knowing that the JCC will not have to approve same. However, with the JCC not being required to approve same, no order will be generated pertaining thereto. As such, failure to pay an E/C paid attorney's fee will result in the bringing of an action outside of the worker's compensation arena, for enforcement of the contracted provision.

CONTRIBUTION BETWEEN CARRIERS: Where multiple dates of accident are involved, a claimant's prior industrial accident with one E/C will not permit a subsequent E/C from being able to avoid payment of benefits even where the first industrial accident is more than 50% of the cause for the claimant's need for benefits, so long as there is a causal connection between the claimant's employment with the second E/C and his injury.

Pearson v. Paradise Ford, 32 Fla. L. Weekly D 373, decided February 5, 2007.

This case involved a claimant who sustained injury to his back on two different dates, with two different E/Cs. The main issue before the Court was whether the JCC correctly determined the liability of the two E/Cs. An ancillary issue was whether the JCC's award of benefits through the date of an MRI that showed no objective medical findings, when the claimant was previously placed on a no work status by his authorized treating physician, was proper.

Both E/Cs denied the petitions filed against them. E/C #1 argued that the claimant's second industrial accident was an intervening cause and the major contributing cause of his injuries, while the second argued that the claimant's pre-existing condition was the major contributing cause of his injuries.

The JCC determined that the claimant's first accident was 80% responsible for his injuries and the second accident was 20% responsible for same. Applying Section 440.09(1)(b) (2003), the JCC determined that the second E/C was not responsible for any benefits because the second date of accident was not more than 50% of the cause of the claimant's injuries. At the same time, the JCC held that the first E/C was only responsible for paying 80% of the indemnity and medical benefits owed to the claimant.

As to the primary issue before the Court, the Court determined that Section 440.09(1)(b) is not the

section that governs the JCC's responsibilities regarding contribution between carriers. Instead, the Court held that Section 440.42 (3) (now Section 440.42(4)) is the controlling statute.

The Court determined that the JCC erred by not holding the second E/C responsible for 20% of the benefits awarded. The Court explained, in dicta, its rationale behind its determination that Section 440.09(1)(b) did not apply and that Section 440.42(3) (now Section 440.42(4)) did. Therein the Court suggested that the 2003 amendments to Section 440.09(1)(b) were intended to "...apply only when the claimant's need for treatment or benefits is caused by the impact of an employment accident combining with a preexisting injury or condition that is unrelated to an employment accident." The Court stated that applying Section 440.09(1)(b) to situations where multiple employment accidents combine, causing the claimant's need for benefits, but no single accident was more than 50% the cause of same, would preclude the claimant from receiving any benefits whatsoever. The Court stated that the Florida legislature could not have intended such a result.

As to the other issue, the Court cited their prior ruling in *Garcia-Vina v. U.S. Holiday Health and Recreation*, 634 So.2d 200, 201 (Fla. 1st DCA 1994), wherein the Court determined that a claimant is entitled to indemnity benefits even if the medical

evidence shows that the claimant did not have a disability, if the same was never communicated to the claimant.

This case is controversial and will no doubt be utilized by claimant's attorneys to increase the amount of benefits owed to the claimant, by allowing the claimant to dip his hand into more pockets. As it stands, this case requires E/Cs to pay benefits to

FRAUD: A JCC's determination of whether a claimant has committed fraud will be upheld, if it is based on competent, substantial evidence.

Pavilion Apartments v. Wetherington, 31 Fla. L. Weekly D 2772b, decided November 6, 2006.

From a factual standpoint, this case involved a claimant who sustained a compensable injury and was accepted as permanently and totally disabled. After several years of providing permanent total disability benefits, the claimant's updated deposition was taken. During that deposition, the claimant was questioned about his functional capabilities. In particular, he was questioned about his ability to walk and stand without his cane. In that regard, he testified that he does not walk very well without his cane and did not do it because he used it to help carry a lot of his weight. He was then asked if he had an altered gait when he did not use it and he testified affirmatively. Surveillance of the claimant had been obtained and the E/C asserted a fraud defense and denied all benefits based on an allegation that the claimant misrepresented his functional ability during his deposition. The JCC found that the claimant had not committed fraud and the E/C appealed the JCC's ruling.

On appeal, the Court determined that defense counsel misstated one of the JCC's key findings of fact. Defense counsel included the following language in his brief: "On video, the Claimant walked without [sic] the cane except for March 13, 2004." The footage showed the opposite of what the above-quoted language reflected (i.e., the claimant was only viewed on one day walking without his cane and on that day walked with an altered gait or was observed leaning on something stationary for support). The Court ultimately held that the record reflected that the JCC's decision was based on competent, substantial evidence and as such, the JCC's decision that the claimant had not committed fraud was affirmed.

This case has become particularly important due to some dicta that is now being argued to mean that denial of benefits prior to an actual final

claimants, even if the major contributing cause of the claimant's need for same is a pre-existing condition related to a prior industrial accident, despite specific language in Section 440.09(1)(b) to the contrary. It seems that the Court is legislating here, by interpreting Section 440.09(1)(b) in such a way that is in direct contravention to the plain and unambiguous language of that section.

compensation order establishing that the claimant has committed fraud is improper.

While the *Wetherington* Court was concerned that defense counsel "blithely misstated the order under review", they ironically misquoted one of their own prior rulings in the dicta, leading to the controversy. Specifically, the *Wetherington* Court quoted the following language from *Isaac v. Green Iguana, Inc.* 871 S0.2d 1004, 1007 (Fla. 1st DCA 2004):

"Section 440.09 (4) contemplates that, before benefits may be denied pursuant to the statute, there must be a showing [**and an official determination**] that the claimant made 'oral or written statements concerning facts material to his claim that he knew were false, misleading or incomplete at the time the statements were made.'"

The portion of the quoted language in bold type does not appear anywhere in the four corners of the Court's opinion in *Isaac*. *Id.* Instead, the *Wetherington* Court inserted this language for unknown reasons. Unfortunately, the language seems to be clear. Per a strict interpretation of this language, an E/C would be precluded from denying benefits until after a JCC has made a determination of fraud. This potentially has serious implications as no determination of fraud can be made unless a petition is pending. At present, this case is final and the Court has not issued any other opinions wherein they have receded or overturned their holding in this case.

It is important to note that the language at issue is dicta. The holding in this case had nothing to do with whether benefits were properly denied, during the pendency of litigation. In fact, no prior fraud cases have ever held that benefits cannot be

denied until after a formal finding of fraud has been made. The holding in *Isaac* does not even support the position the Court appears to be taking. In that regard, *Isaac* dealt with an issue of due process. In *Isaac*, the Court held that failure to assert a fraud defense prior to trial, pursuant to the appropriate rules of procedure deprived the claimant of due process. In the instant case, the E/C had properly filed a notice of denial, providing the claimant with proper notice

of their denial, allowing her to prepare arguments in rebuttal to the E/C's fraud defense, providing her notice and an opportunity to be heard. As such, the Court's decision in *Isaac* does not appear to have any relevance to the issues presented in *Wetherington*. Thankfully, because *Isaac* is mentioned in dicta, the Court's misquote arguably does not provide a binding precedent.

MEDICAL TRANSPORTATION: Medical mileage incurred while traveling to pharmacy to pick up prescription medication prescribed by authorized physician deemed compensable.

Remington v. City of Ocala, 31 Fla. L. Weekly D 2722a, decided October 31, 2006.

The sole issue that was appealed in this case was the JCC's denial of reimbursement for medical mileage submitted by the claimant relating to travel to and from his pharmacy, incurred in order to pick up prescription medicine prescribed to him by his authorized treating physician. The JCC held that the Florida Workers' Compensation Law did not require an E/C to provide reimbursement to an injured worker for such travel. The First District Court of Appeal ultimately reversed the JCC's ruling and remanded the case for further proceedings consistent with their holding.

responsible for reasonable travel expenses incurred by the employee in presenting himself at the place where treatment and care is provided. *Id.* at 47.

In *Remington*, the Court extended the meaning of *Mobley*, by determining that the JCC erred in finding that the act of going to a pharmacy does not fit within the definition of treatment. The First District Court of Appeal held that the definition of treatment per Section 440.13 (2006) includes medicine. In the Court's logic, the medicine does nothing for the claimant until it is picked up. As such, travel to and from a pharmacy is necessary in order for treatment to occur.

It is well settled law that an E/C is responsible for providing the claimant with "travel expenses incident to medical treatment". *Mobley v. Jack & Son Plumbing, 170 So.2d 41, 46 (Fla., 1964)*. The Court in *Mobley* held that the proper interpretation of Section 440.13 is that the E/C is

This ruling has unfortunately created a new area of exposure for E/C's, since claimants are specifically permitted to choose their pharmacy per Section 440.13 (3)(j)(2006).

RES JUDICATA: A Court's prior ruling as to indemnity benefits can be res judicata as to a request for indemnity benefits for a different period of time, if the determinative issue was previously addressed in the Court's initial decision.

U.S. Block Windows v. Dixon, 31 Fla. L. Weekly D 2813a, decided November 8, 2006.

The claimant initially sustained an injury to her right shoulder. Over time, she began to have left shoulder complaints. The claimant filed a petition seeking benefits relating to her right shoulder. Subsequently, she filed a petition seeking benefits relating to her left shoulder. Prior to the Final Hearing on the merits of the claimant's first petition, she voluntarily dismissed her second petition. However, she filed two more petitions relating to her alleged left shoulder injury prior to the Final Hearing. The Final Hearing took place on March 30, 2005. Specific periods of indemnity were claimed. The JCC granted some of the periods requested and

denied others. The JCC denied certain periods because he found that the

"[c]laimant had failed to prove the occupational cause of any injury to the left shoulder, had failed to show objective medical findings supporting a disability, and had failed to prove that the work for the employer was the major contributing cause of the injury."

A motion for clarification was filed and granted. The claimant was informed that the JCC felt

it was necessary to determine whether the claimant had demonstrated a compensable left shoulder injury, given that she had provided testimony with regard to same during the Final Hearing.

Thereafter, the claimant obtained an IME. That physician performed an MRI and diagnosed the claimant with a SLAP tear of the left shoulder, which he related to the claimant's employment. A second Final Hearing was held on October 14, 2005 to determine the merits of the claimant's outstanding petitions (3rd and 4th) filed prior to the first Final Hearing concerning her left shoulder. The JCC deemed the left shoulder injury compensable and awarded the claimant TPD benefits for the period he previously denied and beyond, as well as authorization of an orthopedic surgeon. The E/C appealed that award of benefits, asserting that the doctrine of res judicata precluded same.

Despite the fact that part of the time period to which the claimant claimed entitlement was after the first Final Hearing, the Court determined that the JCC's focus during both Final Hearings was on the medical question of the causal relationship between the accident and the claimant's symptoms. Accordingly, the Court held that the benefits requested in the later petitions were barred because they were ripe for adjudication at the time of the first Final Hearing. As such, the award of TPD benefits and authorization of an orthopedic surgeon were reversed.

The importance of this ruling is that defense counsel may successfully assert a res judicata defense in situations where there has been a change in circumstances or new facts developed, but the determinative issue was previously ripe for adjudication at the time of a prior hearing or ruled on in their favor by the JCC at a final hearing.

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