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LEGAL UPDATE

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2009 Under the Gold Dome

What Have They Done Now?

State Representative Edward H. Lindsey, Jr. (R-Atlanta)

The mood in the General Assembly this year was understandably serious and grim due to the weighty economic downturn that had to be worked through. In the end, an austere budget of \$18.6 billion was passed - \$2.6 billion less than was passed only a year earlier.

In regards to legal issues, the session focused primarily on bread and butter reforms on a wide range of issues and also left plenty on the table for further debate. Keep in mind that 2009 is simply the first act of a two act play and a great deal of the issues raised this year will not be resolved until the last day of the session next year.

I. Bills Passed

a. Business Law -- Welcome to the 21st Century

HB 126 – Uniform Electronic Transactions Act

Georgia now becomes the 47th state to pass the Uniform Electronic Transactions Act (“UETA”). It basically takes generally accepted business and contract principles and applies them to business transactions taking place over the internet. For those who wish to conduct business electronically, the Bill covers everything from how offers and acceptances are handled and electronic signatures and notaries are perfected, to requiring that both parties be able to download to their own computer the final agreed upon terms of the agreement – and everything in between.

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.

HB 127 – Uniform Real Property Electronic Recording Act

The Uniform Real Property Electronic Recording Act (“URPERA”) grants responsibility to the Georgia Clerk’s Authority to county clerks to accept filing of real estate transactions by electronic means. In addition, the Authority will be vested with the responsibility for establishing uniform regulations for how these electronic transactions will be handled in all 159 Georgia counties.

b. Domestic Law and Juvenile Court Proceedings

HB 145 – Child Support Revisions

In the 2006 rewrite of the Georgia Child Support laws, the General Assembly also created the Georgia Child Support Commission to monitor how the new law was working and to make suggested modifications as the need arises. HB 145 contains this year’s recommended changes dealing with deviations required in situations involving parents with very low income. The Bill basically gives the judges greater discretion to set aside the child support tables in fixing the level of child support in such situations.

HB 189 – Child Support Collection Agencies

Child support collection agencies have existed for some time in Georgia primarily targeting low income families that cannot be helped by the State Child Support Recovery Agency. This Bill provides greater regulation of these services by capping the maximum amount of fees they can charge at 33% and requiring that their standard contracts must be approved by the Governor’s Consumer Affairs Office.

SB 207 & HB 254 – Juvenile Proceedings

There has long been a debate over whether juvenile court proceedings should be confidential and closed. Generally, under SB 207, juvenile court hearings after January 1, 2010, will be open to the public except in the following circumstances:

- (A) The proceeding involves an allegation of an act which, if done by an adult, would constitute a sexual offense under Chapter 6 of Title 16; or
- (B) It is in the best interest of the child. In making such a determination, the court shall consider such factors as:
 - (i) The age of the child;
 - (ii) The nature of the allegations;
 - (iii) The effect that an open court proceeding will have on the court's ability to reunite and rehabilitate the family unit; and

- (iv) Whether the closure is necessary to protect the privacy of a child, of a foster parent or other caretaker of a child, or of a victim of domestic violence.

HB 254 deals with juvenile court deprivation and abuse proceedings where the child is being removed from his or her parents. In cases in which the child is to remain out of the parent's custody for more than 30 days, the court shall look first to relatives of the child for placement.

c. Civil Practice

HB 29 – Service by Electronic Means, Stay of Discovery Pending Motion to Dismiss

This Bill blended together two different proposed changes to the Georgia Civil Practice Act. First, it sets out a method for how attorneys in a civil action may agree to serve all pleadings after the complaint by electronic means. For those attorneys that agree to accept pleadings electronically, the three-day mail rule still applies.

Second, the Bill allows for a 90-day stay of discovery if a Defendant files a 12(b)(6) Motion to Dismiss at or before the filing of his answer.

HB 195 – EMC Members on Juries

In more rural areas, there has been a great problem with selecting juries in cases that involve the local Electrical Membership Corporations because so many jurors belonged to the EMC. This Bill simply allows prospective jurors to serve on in such cases even though they belong to the EMC.

HB 283 – Filing fees in Appellate Courts; Fees for Taking the Bar

The cost of appealing a civil case to the Georgia Court of Appeals or Supreme Court is about to increase dramatically. The cost is being increased from \$80.00 to \$300.00. The cost for appealing criminal and habeas actions remains at \$80.00.

In addition, responsibility for setting the fee for taking the Bar Examination is now with the Georgia Supreme Court.

HB 324 -- State Courts, Payment of Cost on Appeal

The law currently requires that in any appeal from a lower court to the superior court the appellant is required to pay all cost of the tribunal appealed from. HB 324 requires that any appeal to the state court from a lower court be similarly treated in terms of the payment of costs.

SB 213 – Market Share Liability in Products Liability Cases

This Bill bars products liability cases in which a manufacturer of an allegedly defective product is sought to be held liable for a public nuisance on theories of market share or enterprise, or other theories of industry wide liability.

HB 529 – Agritourism, Good Faith Immunity

This Bill recognizes the inherent risks involved in agritourist activities, including hunting, fishing, apple picking, etc. The owner of property who properly posts warnings of this danger and obtains a signed waiver from guests will enjoy good faith immunity from civil law suits.

d. Real Estate Law

HB 315 – Mortgage Brokers

Within the mortgage industry, concerns have been raised about mortgage brokers receiving undisclosed fees (or “kickbacks” as critics call them) from mortgagors for steering borrowers to one kind of loan or another. HB 315 bars mortgage brokers from receiving any kind of fee or commission that is not fully disclosed to the borrower.

SB 141 – Foreclosure Deficiency

This foreclosure Bill simply requires that within 90 days of a foreclosure sale, the transfer deed under the power of sale shall be recorded.

HB 608 – Time Shares

This Bill creates an alternative method for buying and selling timeshare interest in property. It allows for such developments to hold the property in trust for the express benefit of timeshare owners. Owner Associations shall also act as a fiduciary of timeshare owners.

e. Judiciary

HB 221 – Removal of Judges

This Bill simply requires that before a writ of mandamus or prohibition may be applied for a party must first move to recuse the judge, if such a motion is available.

HB 495 – Associate Probate Court Judges

This Bill allows for Probate Judges, subject to the approval of his or her County Commission, to appoint part-time and full-time Associate Probate Judges. These judges must meet the same qualifications as the Probate Judge. In the case of full-time Associate Probate Judges, they cannot engage in any private practice. In the case of part-time Probate Judges, they cannot practice in the probate court in which they serve as a judge.

SB 199 – Suspension of Magistrate Training

In an unfortunate sign of the times, this Bill allows the Council of Magistrate Court Judges to suspend continuing education requirements for 2009 and 2010.

HB 718 – Fulton Judges Compensation Act

This Bill simply requires that the Fulton County Commission make available to the judges of the Superior Court of Fulton County all health, dental, mental health, vision, prescription drug, disability, and life insurance benefits and other similar benefits which are made available to other employees of Fulton County. Such benefits must be made available to the judges on the same basis as such benefits are made available to other employees of Fulton County.

II. Bills Left for Consideration in 2010

a. Civil Practice

HB 24 – Evidence Code

The long awaited revision to the Georgia Evidence Code was finally completed by the State Bar Commission last spring and presented to General Assembly for its consideration. Chairman Wendell Willard conducted hearings last Summer and Fall to attempt to reach a consensus from the various stakeholders. Unfortunately, the Bill has now stalled due to strong opposition from the State's district attorneys and solicitors. The Bill managed to get out of the House Judiciary Committee, but failed to get to the House floor. Its chances of passing in 2010 are very doubtful unless citizens work very aggressively for its passage.

HB 220 – Judges Timely Issuing of Orders

How many times have you watched a case languish in court pending a decision by a judge on a motion and muttered to yourself, "there ought to be a law requiring the judge to decide quicker." Well, in reality there already is such a law. It is O.C.G.A. 15-6-21. The problem is that in its present form it is probably unconstitutional because it creates different deadlines depending on the size of the county (30 days for courts operating in

counties with less than 100,000 residents and 90 days with more than 100,000 residents) and under the Georgia Constitution laws based on population size are unconstitutional.

HB 220 would bring uniformity to the law by setting a 90-day deadline for all courts. The Bill passed the House and is in the Senate Judiciary Committee.

HB 235 – Publishing of Rules of Court

Present law requires that the Georgia courts publish each year their Rules of Court. HB 235 would simply change the requirement by allowing that the rules be published on the internet. The Bill passed the House and it is currently in the Senate Judiciary Committee.

HB 545 – Commencement of Civil Action, service of process

For several years the Bar has been battling with the Sheriff's Association in the General Assembly to open up service of process to private process servers. This Bill allows for the statewide registration of private process servers who can be hired by parties in a lawsuit to serve papers without first obtaining leave of court. In addition, the Bill contains a safeguard against a plaintiff serving a party and then withholding filing the proof of service until after the case goes into default. Under this Bill, a party must file the proof of service from a private process server within five days of service. If he does not, the time period for answering the complaint is stayed until the proof is filed.

The Bill passed the House and is currently pending in the Senate Judiciary Committee.

HB 357 – Court Reporters, right to transcription

The Bill attempts to insure that parties are fully aware of both their right to have a court reporter and the consequences of not having a transcript on any appeal. The Bill requires that these rights be fully explained to the party by his or her attorney if he or she is represented or the judge if the party is acting pro se.

The Bill is currently in the House Judiciary Committee.

b. Business Law

HB 173 – Restrictive Covenants – restraint of trade // HR 178

The Georgia Constitution prohibits contracts that “have the effect of defeating or lessening competition.” As a result, Georgia courts take a very dim view of restrictive covenants in business and employment contracts and will void the entire contract if any portion is determined to be overly broad or restrictive. HR 178 would modify the

constitution to specifically allow the General Assembly to create rules to allow for such contracts and require courts to “blue line” contracts to only void the portions it deems overly broad without voiding the entire contract. HB 173 is the enabling legislation that will only go into effect if the constitutional amendment passes voter approval in 2010.

The constitutional amendment is currently in the House Judiciary Committee.

HB 451 – UCC 7 revision

Like all other aspects of business transactions, Title 7 of the UCC needs to be dusted off and brought into the 21st Century. HB 451 allows for the transfer of commercial paper by electronic means. The Bill passed unanimously out of the House and is currently in the Senate Special Judiciary Committee.

c. Real Estate Law

SB 57 – Disclosure requirements for home loans and certain procedures prohibited

This Bill attempts to deal with allegedly abusive practices in the process of obtaining a mortgage. It would specifically ban the following:

1. *Negative amortization* -- any payment term under which the outstanding principal balance on a home loan will increase at any time over the course of the home loan because the regular periodic payments do not cover the full amount of the interest that accrues on the underlying principal. Such term shall not include reverse mortgage transactions;
2. *Prepayment charge* --any fee, charge, penalty, or premium that is required to be paid to a lender when all or any portion of the outstanding principal amount is repaid on a home loan before its scheduled time of maturity; and
3. *Yield spread premium* -- any form of direct or indirect compensation that a mortgage broker, acting as the intermediary between a borrower and a lender, receives in connection with placing a borrower in a home loan with a higher interest rate than the lender's par rate for which the borrower qualifies.

The Bill passed the Senate and is currently in the House Judiciary Committee.

d. Judges

HB 514 – Use of Senior Judges

This Bill restricts senior judges from presiding over cases in which the constitutionality of an act is challenged. The Bill bars the senior judge unless: 1) he or she was presiding over the case before he or she went to senior status; 2) an elected judge

determines that the challenge is without merit; or 3) the challenge is raised after the entry of a pretrial order.

Different versions of the Bill have passed both the House and Senate and it is currently in Conference Committee.

HB 601 – Independent Political Committees; Judicial Recusal

The Bill attempts to regulate independent committees and insure that judges maintain both actual and perceived impartiality. It requires that independent political committees fully disclose their contributors. In addition, if an attorney or party to a lawsuit contributes through direct contributions to the candidate and additional contributions to independent committees more than \$8,000.00, the opposing party will have the right to move for recusal. The Bill also encourages judges to raise contributions only through campaign committees instead of making direct solicitations by requiring the judge to recuse his or herself from a case if the judge made a direct solicitation to a party or lawyer in a case.

The Bill is currently in the House Judiciary Committee.

e. Miscellaneous

HB 16 – Electronic Devices placement without consent

This Bill would outlaw placing onto any automobile an electronic tracking device without the consent of the owner. The Bill allows for exceptions for law enforcement and parents of minors.

The Bill passed the House and is currently in the Senate Judiciary Committee.

HB 23 – Cell Phone Use by New Drivers

This Bill will bar new drivers with two years or less of experience from being able to use a cell phone or text message while driving. Young drivers who violate this law and have an accident while doing so will have their license suspended.

This Bill passed the House and is in the Senate Judiciary Committee.

f. And Justice for All

SB 42 – Georgia Public Defender Standards Council

Who should set the policies for indigent defense in Georgia? How do we handle conflict cases? What, if any, role should the Governor have in selecting the Executive

Director? How should the Council be appointed?

SB 42 passed out of the Senate but stalled in the House. In the final hours of this year's session a compromise began to emerge but could not get passed before the session closed out. The compromise would reorganize the Council with a majority of the members appointed by the governor. The Council would maintain control over policy and select the executive director – subject to the approval of the governor. The Council would also oversee a separate division for conflict cases. The Executive Directors of both divisions would have the authority to negotiate contracts with private attorneys.

This compromise will be pushed again in the 2010 session.

III. Going, Going Gone -- Bills off the Table For This Term

HB 200 – Seat belt Use

The “Tom Murphy Rule” states that the failure to use a seatbelt by a plaintiff cannot be considered by a jury in order to mitigate damages. This Bill was designed to change that rule and allow for such consideration. After getting out of the Judiciary Committee by a narrow vote it proceeded to be crushed on the House floor by a staggering margin. Interestingly, a similar measure passed overwhelmingly in the Senate (SB 23). However, given its overwhelming rejection by the House, the Spirit of Tom Murphy should keep this change from happening for a while.

IV. Conclusion

It continues to be critical for lawyers and judges to become more involved in the legislative process. This year there are only 22 members of the Georgia House of Representatives who have a bar license. The number who actively practice law is in the low teens and only a handful actually engage in litigation. As a result, input from individual lawyers is more critical than ever.

For more information on individual Bills or contact information on your Representative or Senator please visit the Georgia Legislative website <http://www.legis.state.ga.us>.

CASE NOTES

Georgia Liability

PREMISES LIABILITY/AUTOMOBILES: Application of “acceptance doctrine” precludes finding of liability against contractor who only repaired, but did not design, section of road where accident occurred.

Bragg v. Oxford Construction Company, 2009 WL 290003 (Ga.), decided February 9, 2009

Husband and wife were involved in a serious automobile accident in Dougherty County. As a result of injuries sustained in the accident, the couple’s unborn child was stillborn. The couple brought an action for negligent road construction against Oxford Construction Company, the contractor that performed the work on the section of road where the accident occurred. The Superior Court of Dougherty County entered summary judgment in favor of Oxford. The Court of Appeals affirmed the ruling and the Supreme Court of Georgia granted certiorari to determine whether the “acceptance doctrine” remains viable in Georgia.

The acceptance doctrine provides that where a contractor who does not hold itself out as an expert in the design of the work that is at issue, performs its work without negligence and that work is subsequently approved and accepted by the owner or on the owner’s behalf, the contractor is not liable for injuries which occur as a result of the defective design. Exceptions to this rule apply where the work is inherently or intrinsically dangerous, constitutes a nuisance per se, or is so negligently defective as to be imminently dangerous to others.

In this case, Dougherty County contracted with Oxford Construction to repave and overlay asphalt patches on a section of road owned and maintained by Dougherty County. A County engineer supervising Oxford’s work directed Oxford to place a “spot overlay patch”

on the section of the road where the plaintiffs’ accident occurred. Oxford followed the engineer’s specific instructions and the County ultimately approved and accepted Oxford’s work, at one point even denying Oxford’s request to repair what it observed was a problem with the finished product.

As Oxford merely performed the contracted work pursuant to the County’s specifications, was neither responsible for the design of the road nor held itself out as an expert in the area of road design, and performed its work without negligence, the County’s subsequent approval and acceptance of Oxford’s work resulted in the application of the acceptance doctrine, and the Court of Appeals’ ruling was affirmed.

HIPAA/PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY: Wife, as surviving spouse, is entitled to husband's medical records to pursue wrongful death action against nursing care facility.

Alvista Healthcare Center, Inc. v. Miller, 2009 WL 368393 (Ga. App.), decided February 17, 2009

Mary Miller brought a wrongful death action against Alvista Healthcare Center, the owner of the nursing facility where Miller's deceased husband lived. Before filing suit, Miller asked Alvista to provide copies of her deceased husband's medical records. Alvista refused, claiming that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its privacy regulations prevented Alvista's production of the requested records.

The trial court granted Miller's petition for relief and ordered Alvista to produce the medical records for Miller's deceased husband. Alvista appealed and the Court of Appeals reversed.

The intent of HIPAA is to ensure the integrity and confidentiality of patients' information and to protect against unauthorized uses or disclosures of the information. With regard to deceased individuals, HIPAA's privacy rule provides that if an executor, administrator, or other person has authority to act on behalf of a deceased individual or the individual's estate, a covered entity such as Alvista must treat such person as a personal representative with respect to protected health information relevant to the personal representative.

A January 31, 2007 ruling from the Office for Civil Rights ("OCR") concluded that before a health care provider can disclose

protected health information to an individual's personal representative, the privacy rule requires: (1) authority by the personal representative to act on behalf of the individual or estate; (2) authority by the individual under state law to access the protected health information; and (3) relevance of the protected health information to the personal representative.

The Court of Appeals noted that O.C.G.A. § 31-33-2(a)(2)(B) requires a health care provider to furnish a copy of medical records to a surviving spouse of a deceased patient if an executor or administrator for the estate has not been appointed. Further, Georgia's wrongful death statute, O.C.G.A. § 51-4-2(a), provides a right of action for wrongful death to a surviving spouse. Therefore, the court concluded that Miller, as the decedent's surviving spouse, had the authority to act on her husband's behalf in investigating and pursuing a wrongful death action.

Because Miller requested the medical records in her capacity as the surviving spouse who wished to pursue a wrongful death action, the Court of Appeals held that she satisfied the three requirements of the OCR ruling. Accordingly, she was entitled to her deceased husband's records from Alvista.

PREMISES LIABILITY/STATIC DEFECT: Knowledge of danger will be imputed to plaintiff who has successfully navigated area of her trip and fall only when causative static condition is readily discernible.

Cocklin v. JC Penney Corp., 2009 WL 386910 (Ga. App.), decided February 19, 2009

Barbara Cocklin tripped and fell walking into the hair salon at J.C. Penney. The transition from the store to the hair salon involved a slight step with a previously undetected crevice where Ms. Cocklin's shoe apparently was caught, causing her to fall. Prior to her fall, no one else had ever tripped over the threshold and Ms.

Cocklin herself had been to the salon at least four or five times previously without incident. An expert testified on Ms. Cocklin's behalf that the crevice was not readily visible from a normal visual height, creating a dangerous premises defect.

J.C. Penney moved for summary judgment, arguing that the alleged defect in the floor was a static condition, that Ms. Cocklin had successfully navigated the area previously and that the store did not have superior knowledge of the hazard. The trial court granted the motion, finding presumptive knowledge on the part of the plaintiff.

The Court of Appeals reversed, reasoning that the rule imputing knowledge of a hazardous static condition to a plaintiff only applies if the condition is “readily discernible.”

The Court further determined that J.C. Penney had constructive knowledge of the defect in the floor’s transition because it had a duty to exercise ordinary care to inspect the premises for possibly dangerous conditions. Because a jury might find that J.C. Penney’s knowledge of the condition was superior to that of the plaintiff’s, the Court of Appeals held that it was improper to grant summary judgment to J.C. Penney on the basis of the plaintiff’s equal knowledge of the condition.

DEFAULT JUDGMENT: Failure to timely respond to plaintiff’s complaint concludes defendant’s liability and stands as admission to well-pleaded allegations of complaint and any fair inferences.

Countrywide Home Loans, Inc. v. King, 2009 WL 400845 (Ga. App.), decided February 19, 2009

After the holder of a first mortgage in the home of James and Marie King foreclosed on their property, Countrywide Home Loans, which held a second mortgage in the property, filed suit against the Kings on November 8, 2007. The Kings failed to file an answer to the complaint, and on March 25, 2008, Countrywide filed a motion for entry of default based on the Kings’ failure to timely file an answer.

The trial court denied the motion for default based on an issue with the Kings’ filing of a bankruptcy petition and subsequent discharge. Countrywide appealed and the Court of Appeals, applying an abuse of discretion standard, reversed the ruling.

O.C.G.A. § 9-11-55(a) provides that, if in any case an answer has not been filed within the time required, the case shall automatically become in default unless the time for filing the answer has been extended as provided by law. The default may be opened as a matter of right by the filing of such defenses within 15 days of the day of default, upon the payment of costs. If the case is still in default after the expiration of the 15-day grace period, the plaintiff is immediately entitled to verdict and judgment by default.

In this case, the Kings never filed an answer; there was no extension of time to file an

answer; and the Kings did not seek to have the default opened as a matter of right. After the expiration of the 15-day statutory grace period, therefore, Countrywide became entitled to verdict and judgment by default as if every item and paragraph of its complaint was supported by proper evidence, *excluding* the amount of any unliquidated damages.

Despite the trial court’s concern that the Kings may have had a defense related to a discharge in bankruptcy, the default concluded the Kings’ liability and prevented them from offering any defenses that would defeat Countrywide’s right of recovery – even if Countrywide would not otherwise have been entitled to recover. Thus, even if the discharge could be shown by the Kings, it was an affirmative defense that was waived by their failure to timely file a responsive pleading to Countrywide’s complaint.

Since the allegations in the complaint were sufficient to state the outlined causes of action, and as a default operates to admit the well-pleaded allegations and the fair inferences and conclusions of fact to be drawn there from, the Court of Appeals reversed the trial court’s denial of Countrywide’s motion for default and remanded the case to the trial court for a determination as to any unliquidated damages.

SUMMARY JUDGMENT/GROUNDS FOR GRANTING: A trial court may properly grant summary judgment where court considers and rejects argument that it was misled in crafting its orders.

Anders v. State Farm Fire and Casualty Co., 2009 WL 456200 (Ga.App.), decided February 25, 2009

Sir Todd Anders returned home after an extended absence and discovered that trees had fallen on his house. Anders called State Farm, his insurer, to report the damage. When the parties could not reach an agreement as to the amount of the damages, Anders invoked the appraisal clause in his policy. State Farm named its own appraiser and filed a motion to stay the appraisal process until the issue of what damage was covered was decided.

The trial court held that the appraisers should determine the damages that may have occurred in the first ten days after the date of loss. The appraisers would try to reach an agreement on the amount of damages and, if the appraisers could not come to an agreement, the issue would be submitted to an umpire. The agreement signed by any two would set the amount of loss. The appraisers and the umpire all agreed that the amount of loss totaled \$158,000.

Anders asked the court to reconsider the parameters for the appraisal and submitted his own proposed order, which included its own ten-

day clause. Subsequently, Anders' attorney wrote the trial court asking for reconsideration of the ten-day scope of coverage arguing that it was a mistake or misunderstanding in the original order in that the appraisers and umpire never agreed to the ten-day scope of coverage. The trial court rejected Anders' argument. The trial court noted that prior to issuing its order setting the parameters of the appraisal, counsel "hotly disputed" the wording of the order. The trial court noted that, in making that order, the court had considered Anders' current objection and rejected it. State Farm moved for, and was granted summary judgment.

On appeal, Anders argued that the trial court's order on the scope of coverage was based on a misrepresentation by State Farm. The Court of Appeals, however, found that, because the trial court had considered and rejected Anders' argument that State Farm had misled the court, Anders' argument was without merit. Thus, the Court of Appeals affirmed the trial court's grant of summary judgment.

PUNITIVE DAMAGES/RESPONDEAT SUPERIOR: Truck driver's employer cannot be liable for punitive damages based on a theory of *respondeat superior* where driver was discharged from liability for punitive damages.

American Material Services, Inc. v. Giddens, 2009 WL 658087 (Ga. App.), decided March 16, 2009

Jolene C. Giddens sustained back and neck injuries when an 18-wheel tractor trailer driven by Charles Chambers, an employee of American Material Services, Inc., struck her car. Giddens sued under theories of negligence and negligent hiring, retention and entrustment, and also sought recovery for punitive damages against all defendants. The evidence showed the Chambers was returning from making a delivery when his tractor trailer collided with Ms. Giddens' car. Mr. Chambers tested positive for alcohol and was issued citations for driving under the influence and for failure to maintain his lane.

At trial Chambers admitted to consuming at least seven or eight beers shortly before the accident, having three prior convictions for driving under the influence and that his license had been suspended on at least two occasions.

During the charge conference Giddens withdrew her request to charge on negligent entrustment and submitted no requests to charge on the issues of negligent hiring or retention. After hearing all of the evidence, the jury returned a verdict in favor of Ms. Giddens. As to American, they awarded \$85,500 in

compensatory damages and found that punitive damages should be awarded. In the punitive damages phase, the jury returned a verdict finding that Chambers acted under the influence of alcohol, yet imposed no punitive damages against Chambers. Instead, the jury awarded punitive damages against American in the amount of \$50,000.

Before final judgment on the verdict was entered, Ms. Giddens filed a motion for judgment notwithstanding the verdict as to Chambers' liability. Her motion did not address punitive damages. The trial court granted Giddens' motion and amended the jury verdict to award \$85,500 against American and Chambers and also amended the punitive damages award of \$50,000 against American and Chambers, as well. American and Chambers appealed.

The Court of Appeals held that, because Giddens failed to raise the issue of Chambers' liability for punitive damages in her motion, the trial court had no basis for imposing punitive damages on Chambers and its judgment on punitive damages as to Chambers should have been vacated. Furthermore, the only theory of recovery available to the jury was American's vicarious liability for Chambers' negligence. Because Ms. Giddens did not request the jury be charged as to negligent hiring or retention and withdrew the negligent entrustment charge, these theories of liability were not submitted to the jury and were therefore waived. Since American's liability depended solely upon the actions of its employee under the doctrine of *respondeat superior* – and since Chambers had been discharged from personal liability – there were no grounds for an award of punitive damages against American. Accordingly, the judgment was reversed and the matter was remanded to the trial court to enter judgment consistent with the decision.

Georgia Workers' Compensation

SUPERADDED INJURY DOCTRINE: A superadded injury must either be a “natural consequence of” or arise “directly from” the original injury, or must constitute an incapacitation resulting from medical treatment undertaken to cure the work-related injury.

City of Atlanta v. Roach, 2009 WL 929980 (2009)

Richard Roach was a City of Atlanta police officer. He was injured on the job in 2004 when his police vehicle was struck head-on by a drunk driver. Roach suffered a traumatic brain injury and a fractured left hip and pelvis.

In September of 2005, Roach relocated to New York. In March of 2006, he drove to Atlanta to discuss returning to work. Roach made the return drive of some 16 hours in one day. When he arrived home, his hip was sore, so he put a heating pad on it. He fell asleep on the pad, resulting in third-degree burns. He did not feel pain from the burn because of nerve damage in the hip.

Because the burn was not suffered while Roach was working, Roach requested that the City cover medical expenses related to the burn injury as a “superadded injury” under workers' compensation. When the City declined to do so, Roach requested a hearing, seeking an award of the expenses, as well as an award of assessed attorney's fees on the ground that the City's denial was unreasonable.

An administrative law judge ruled for Roach, finding that the burn injury was “related to” Roach's initial injuries and that the use of the heating pad was reasonable and necessary

treatment for Roach's hip. The ALJ awarded medical benefits and \$3,000.00 in attorney's fees.

The City appealed the ALJ's decision to the full Board, which reversed. The Board found that the burn was not a natural consequence of Roach's hip fracture, and that the use of the heating pad was not "medical treatment."

Roach appealed the Board's decision to the Superior Court, which reversed the Board's decision, reinstating the ALJ's initial decision.

The City then appealed to the Court of Appeals, which reversed the Superior Court. The Court of Appeals ruled that the Board had properly applied the holding in *J. M. Huber Corp. v. Holliday*, 228 Ga. App. 4, 491 S.E.2d 74 (1997) that a superadded injury, to be compensable, must be a natural consequence of, or arise directly from, the original work-related injury. The Court of Appeals found that there was evidence to support the Board's conclusion that Roach was burned because he used a heating pad and fell asleep, and that this was not

an injury that was a natural consequence or arose directly from the original injury.

The superadded injury rule has also been applied in cases where the employee was incapacitated due to medical treatment for the original, work-related injury. However, the Court of Appeals ruled that the Board had correctly applied the holding in *Standridge v. Candlewick Yarns*, 202 Ga. App. 553, 415 S.E.2d 10 (1992) that medical treatment within the meaning of the Workers' Compensation law must be prescribed by a licensed physician. Because Roach made his own decision to use the heating pad, and it was not prescribed by a physician, his burn was also not a superadded injury for this reason.

Therefore, Roach's burn was a new injury that was not work-related. Because it was not work-related, it was not compensable.

The Court of Appeals also ruled that the City, by paying the assessed attorney's fees after the ALJ's award, had waived the right to contest the award of fees.

ARISING OUT OF EMPLOYMENT: An act done in furtherance of one's employment, even if personal in nature, is compensable if it results in an injury.

Harris v. Peach Co. Bd. Of Commissions, 296 Ga. App. 225 (2009)

Wendy Harris was employed by Peach County as a custodian at the county courthouse. Her duties included cleaning floors, cleaning restrooms and taking out the trash. On March 17, 2006 was on her way to work on the restrooms when she stopped to speak to her supervisor about work duties. During the conversation, Harris noticed that a diuretic pill she had placed in her pocket was missing. She then saw that the pill was on the floor and as she bent over to pick it up she hear a "pop" in her left knee and collapsed. Ultimately, it was determined that she had an anterior dislocation of her knee and eventually needed two surgeries to repair the injury.

Harris sought workers' compensation benefits contending that her actions arose out of her employment. There was no dispute that her actions were in the course of her employment as

she clearly was working at the time. However,. Peach County contended that Harris' actions were personal in nature and did not arise out of her employment. The ALJ and Appellate Division found in Harris' favor, but the Superior Court reversed. Ultimately, the Court of Appeals ruled in Harris' favor, finding her injury compensable.

This case is an important decision in Georgia as it helps to resolve a dispute between two cases involving "idiopathic" falls or injuries, that is injuries that occur as a result of no specific incident. The two cases are *Chaparral Boats, Inc. v. Heath*, 269 Ga. App. 339 (2004) and *Johnson v. Publix Supermarkets*, 256 Ga. App. 540 (2002). In Chaparral Boats the claimant injured his need while walking across the dock at his work. He was not performing any specific work-related activity at the time. In

Publix the claimant injured her leg while walking quickly down a supermarket aisle to inspect the products. The claim in Publix was found to be compensable, while the claim in Chaparral Boats was not as the claimant's actions in walking across the dock had nothing to do with his job duties.

Here, the Court of Appeals seems to have made a sound legal decision, but used a case with poor facts to reach the conclusion. The Court made a "stretch" of a conclusion that Harris' action in picking up the pill was connected to her employment as her job

included the responsibility of cleaning up the facility. They therefore determined that her action furthered the employer's business because it kept the premises clear and free from debris. We now seem to have a clear definition in similar situation: an action must be done in furtherance of an employer's business for it fall under the coverage of workers' compensation. The Court seemed to forgive the fact that Harris' actions were the result of a personal condition and personal needs, and focused on the benefits derived by Peach County by her actions in picking up the pill that she dropped.

FICTIONAL NEW ACCIDENT DATE V. STATUTORY CHANGE IN CONDITION: An Award or actual payment of benefits is necessary to establish a "condition" in change of condition cases.

Laurens County Bd. of Educ. v. Dewberry, 674 S.E.2d 73, 09 FCDR 676 (2009)

Walter Dewberry was a custodian for Laurens County who injured his knee at work on 8/1/2000. At the time, the County was insured by the Georgia School Board Association Self-Insurance Fund ("GSBA") for workers' compensation.

Dewberry continued to work until he had knee surgery on 9/11/2001 and returned to light duty work six weeks later. GSBA paid Dewberry's medical bills, but never paid any income benefits or accepted the claim as compensable.

In 2004, after the Georgia Education Workers' Compensation Trust Fund ("GEWCT") assumed insurance responsibility for the County, Dewberry sought more medical treatment. By 7/15/2005, his new ATP recommended knee replacement surgery due to his workplace accident.

When GSBA refused to pay for the surgery, Dewberry's ATP gave him work restrictions which the County did not accommodate, and Dewberry was forced to stop working on 11/18/2005. Dewberry then filed a claim with the Georgia Board of Workers' Compensation.

At the hearing, the ALJ considered whether GSBA or GEWCT would be liable for Dewberry's benefits going forward. GEWCT argued that Dewberry underwent a change of

condition for the worse, and that GSBA remained liable for his benefits. However, the ALJ disagreed, finding that Dewberry had a fictional new accident on 11/18/2005. As such, GEWCT, not GSBA, was held responsible for Dewberry's benefits.

The ALJ's Award was upheld at every level. The Court of Appeals noted that where an employer changes workers' compensation insurance carriers, the carrier on the date of a fictional new accident is liable for the claim, even where the condition existed prior to the carrier's coverage.

The Court of Appeals went on to distinguish Dewberry's claim from a statutory change in condition. Because Dewberry was not paid income benefits, either by agreement or award, following his 8/1/2000 accident, GEWCT could not establish a change in condition under O.C.G.A. § 34-9-104.

GEWCT's argument that GSBA *should* have paid Dewberry income benefits following his surgery was unavailing, largely because Dewberry himself did not take steps to establish his entitlement to income benefits at that time. Noting that GSBA's voluntary payment of Dewberry's medical benefits did not constitute an "award" for purposes of O.C.G.A. § 34-9-104, the Court upheld the ALJ's finding of a fictional new accident date.

STATUTE OF LIMITATIONS: An application for additional income benefits, including a catastrophic designation, must be made by filing a Request for Hearing within two years from the last payment of income benefits.

Tara Foods et al. v. Johnson, (A08A1638) decided March 26, 2009

Beverly Johnson sustained a compensable work injury and began receiving income benefits in 1992. The last income benefits were paid on August 28, 2001. She filed WC-14 Notice of Claim in November 2002, and checked the boxes indicating that she was seeking income benefits and wrote "TTD from 8-28-01 for catastrophic designation." However, she did not request a hearing, and no action was taken, as a WC-4 Request For Hearing was not filed. On August 22, 2005 she filed a WC-14 Request for Hearing seeking for medical expenses. This WC-14 not make a reference to catastrophic designation. The medical issue was resolved by consent order, and the case was removed from the hearing calendar. On September 15, 2006, she filed a third WC-14 requesting a hearing. She checked the box for catastrophic designation and continued TTD. The ALJ determined that because more than two years elapsed between the last payments of benefits, the statute of limitations had expired on her request for catastrophic designation.

Two separate statutes of limitations apply to workers' compensation claims. O.C.G.A. § 34-9-82(a) is commonly known as the "all issues" statute, and generally applies to an initial claim for benefits. The second statute of limitations as set forth in O.C.G.A. 34-9-104(b) is commonly known as the "change in condition" statute. It generally applies when someone who has already been awarded workers' compensation benefits seeks additional or new benefits. An application for a change in condition must be made within two years of the last payment of income benefits.

Johnson's request for catastrophic designation is governed by the two year "change in condition" statute of limitation as her claim had been established since income benefits were paid.

The Administrative Law Judge and the Appellate Division found that filing a Notice of Claim for change in condition does not meet the requirement under O.C.G.A. § 34-9-104(b). Even though Johnson knew she might qualify for a catastrophic designation in 2002, she took no action to obtain a decision within the statutory

period. It was not until 2006, more than 5 years after her last payment of income benefits, that Johnson sought a decision on her request for catastrophic designation. Therefore, her application was time-barred.

The Superior Court reversed the Board's decision, but the Court of Appeals reinstated the Board's decision. The Court of Appeals found that Johnson's application for additional income benefits, and specifically her request for a catastrophic designation was not filed within the two-year, change in condition, statute of limitations and therefore was time-barred.

Georgia Coverage

INSURANCE COVERAGE/UNINSURED MOTORIST COVERAGE: Insurer may set off its uninsured motorist coverage by full amount paid from tortfeasor's liability policy, even if part of tortfeasor's payment is used to satisfy hospital lien.

Adams v. State Farm Mutual Automobile Insurance Company, 2009 WL 368503 decided February 17, 2009

State Farm's insured, Randolph Adams, was seriously injured in a car wreck with Hilde Orheiu. Orheiu was insured by Nationwide Insurance Company. During the litigation, Nationwide made two payments (\$9,217.66 to Grady Hospital to compromise Adams' hospital lien and \$15,782.34 to Adams for a limited release) that exhausted the \$25,000 limits of its policy. Adams then sought uninsured motorist compensation from State Farm. A disagreement arose as to the amount of State Farm's coverage, as State Farm claimed that it should be entitled to a setoff for the entire \$25,000 of liability coverage paid by Nationwide.

Adams and State Farm filed motions for summary judgment. The trial court denied Adams' motion and granted State Farm's motion, allowing State Farm to take the entire \$25,000 credit.

O.C.G.A. § 33-7(b)(1)(D)(ii) defines an uninsured motor vehicle as one in which the tortfeasor has liability insurance but the "available coverages" are "less than the limits of the uninsured motorist coverage provided under the [tortfeasor's] insurance policy." The statute provides that "available coverages" are determined by subtracting the available liability coverage from the available uninsured motorist coverage. In this case, the Court of Appeals considered whether the payment made by Nationwide to Grady Hospital in satisfaction of the hospital lien constituted "payment of other claims or otherwise" that would have reduced the maximum amounts payable under the limits of liability coverage, thereby increasing uninsured motorist coverage in a reciprocal fashion.

The Court of Appeals held that the legislative intent of the uninsured motorist

statute is to place the insured in the same position they would be in relation to coverage if the tortfeasor causing the injuries had obtained at least the minimum prescribed liability insurance. If hospital bills or liens constitute payment of "other claims or otherwise," uninsured motorist coverage would automatically be increased every time an insured receives treatment at a hospital and the hospital receives payment for the treatment under the liability policy. The Court of Appeals held that this would frustrate the intent of the uninsured motorist statute.

However, the Court of Appeals noted that the situation is different if the payment involves reimbursement of federal claims. The Court of Appeals considered two prior cases: *Thurman v. State Farm Mutual Automobile Ins. Co.* and *Toomer v. Allstate Ins. Co.* Both of these cases involved repayment of federal claims which, due to the mandatory language of the federal statutes, will reduce the amount of "available coverage."

INSURANCE COVERAGE/ OCCURRENCE AND ACCIDENT: Despite intoxication, intentional acts that resulted in unintended bodily injury were not covered occurrence under homeowner's policy.

Perry et al. v. State Farm Fire and Casualty Company, 2008 WL 5274597 (Ga.App), decided December 22, 2008

Tara and Ron Perry sued Richard Alan Blackwell after Blackwell performed sexual acts on Tara Perry when she fell asleep on Blackwell's couch after a game of cards. In an amended complaint, Perry alleged that Blackwell was intoxicated and due to his intoxication, was negligent in failing to take reasonable steps to ensure that Perry consented to the sexual acts. Blackwell admitted to being intoxicated and stated he believed Perry consented to the acts.

Blackwell's homeowner's insurance provider, State Farm Fire and Casualty Company, undertook Blackwell's defense pursuant to a reservation of rights and filed a declaratory judgment action against Blackwell and Perry, seeking a determination that there was no coverage for Blackwell under his homeowner's policy.

The State Farm policy covered "a claim... for damages because of bodily injury... caused by an occurrence." The policy defined "occurrence" as "an accident, including exposure to conditions, which results in: ... bodily injury..." State Farm argued that Blackwell was not covered because Blackwell's acts were not an occurrence/accident as required by the policy. The trial court agreed and granted summary judgment in favor of State Farm. Perry and Blackwell appealed, arguing that Blackwell's acts were accidental because he was intoxicated and unaware of Perry's lack of consent.

The Court of Appeals found that the policy did not cover accidental injuries unless they were caused by accidental occurrences. An accidental injury (which is not covered) is an injury that is unexpected, but that may arise from a voluntary act (i.e., the act was intended but the consequence was not). However, an injury caused by an accidental occurrence (which is covered) is one that is the unexpected result of an unforeseen act that was unintentionally done (i.e., both the act and its consequence were unintended). The Court of Appeals found that since Blackwell intended to commit the sexual acts with Perry, Perry's resulting injuries were not caused by an accidental occurrence and thus not covered by the State Farm policy.

The Court of Appeals distinguished this case from *State Farm Fire and Casualty Co. v. Morgan*, 185 Ga.App. 377 (1987), where the Court found that there was a question of fact as to whether a deceased gunman was so intoxicated so as to create a question regarding his intent to shoot a gun. In the present case, Blackwell, who was not deceased, admitted that he had the *specific intent* to initiate sexual contact with Tara Perry. As a result, the Court of Appeals found there was no question of fact regarding Blackwell's intent to act.

Accordingly, the Court of Appeals affirmed the trial court's ruling granting summary judgment in favor of State Farm.

POLICY AMBIGUITY/TIMELY NOTICE OF CLAIM: Ambiguous language in contract will be construed against insurer, and while insurer has right to timely notice of claim, it may waive right by assuming defense of insured with knowledge of untimeliness.

State Farm Fire and Casualty Co. v. Walnut Avenue Partners, LLC, et al., 2009 WL 658636 (Ga.App.), decided March 16, 2009

Sharad Desai and Anil Naik operated Big B Cleaners of Dalton ("Big B"), which leased its space from Walnut Avenue Partners ("Walnut"). Walnut discovered that Big B was causing pollution in the area, and sought to

increase its rent. Big B subsequently decided not to renew its lease. After failed attempts by Walnut to be indemnified for the pollution, Walnut filed a lawsuit on April 25, 2002 against Big B and against Desai and Naik in their

individual capacities. On April 30, 2002, Big B notified State Farm of the lawsuit.

State Farm initially assumed the defense of both the corporation and the individual defendants subject to a reservation of rights. Subsequently, State Farm notified Big B that it would no longer provide a defense to the lawsuit because the claim was not covered. Walnut sought a declaratory judgment from the court to establish State Farm's coverage obligation to Big B. State Farm moved for summary judgment on the ground that Big B failed to timely notify it of the situation. Big B, in turn, moved for summary judgment on the ground that State Farm waived its timeliness argument when it assumed the defense.

The trial court denied summary judgment and held that the State Farm policy provided coverage for quick, abrupt and accidental pollution.

On appeal, State Farm argued that the trial court's ruling contradicted the unambiguous language of the policy. The Court said that contracts must be looked at in their entirety, including all amendments. In doing so, the Court found inconsistent language in two amendments to the original contract, which it determined to be ambiguous, and stated that any exclusions to coverage in an insurance

agreement must be defined clearly and distinctly. O.C.G.A. § 13-2-2(4). It further stated that ambiguous language in an insurance contract will be construed against the insurer and in favor of the insured. O.C.G.A § 13-2-2(5). The Court of Appeals upheld the trial court's ruling.

On the issue of timeliness, the evidence showed that Big B first learned of the pollution in 1999, but did not notify State Farm of the issue until the lawsuit was filed in 2002. Big B argued that it was not aware that the contamination would lead to property damage within the parameters of the policy. The Court said that while an insured is not justified in failing to notify the insurer due to a belief that a certain incident may not be covered under the policy, the insured is also not expected to foresee every possible claim that might arise from an incident. The Court affirmed the trial court's denial of State Farm's motion for summary judgment.

The Court further held that because Desai and Naik signed a reservation of rights form in their individual capacity and on behalf of Big B, State Farm did not waive its untimely notice claim. Accordingly, the Court of Appeals affirmed the trial court's denial of summary judgment to Big B on this claim, as well.

<h2>Georgia</h2> <h3>Underinsured/Uninsured Motorist</h3>

UNDERINSURED MOTORIST COVERAGE/SETTLEMENT/LOSS OF CONSORTIUM: Payment of liability limits to husband and wife for husband's bodily injury claim and wife's loss of consortium claim may exhaust liability limits for purpose of making underinsured motorist claim if wife does not receive any proceeds of settlement.

Thompson v. Allstate Ins. Co., 2009 WL 290183 (Ga.S.Ct.), February 09, 2009 and Allstate Ins. Co. v. Thompson, 2009 WL 657701 (Ga.Ct.App.), March 16, 2009

The Thompsons were involved in an automobile accident. Mr. Thompson brought suit for his personal injuries and Mrs. Thompson

brought suit for loss of loss consortium. In addition to filing suit against the negligent driver, the Thompsons served their uninsured

motorist carrier with a copy of the complaint to initiate an underinsured motorist claim.

The Thompsons settled with the negligent driver's liability insurance carrier for the \$100,000 policy limits. In return, the Thompsons signed a limited liability release that provided the purpose of the settlement was for the plaintiffs to pursue claims against their underinsured motorist carrier.

The underinsured motorist carrier filed summary judgment arguing that because the policy limits of \$100,000 was paid to both Mr. and Mrs. Thompson, neither plaintiff fulfilled the condition precedent that the liability limits must be exhausted before pursuing an underinsured motorist claim. The Thompsons' lawyer responded with an affidavit stating the settlement was for Mr. Thompson's claims and not Mrs. Thompson's claim for loss of consortium, which was nominal and not worth pursuing.

The trial court granted summary judgment to the UM carrier on Mrs. Thompson's claim, but denied summary judgment for Mr. Thompson's claim because there were disputed facts about the intent of the settlement.

The Georgia Court of Appeals reversed the trial court and held that, because \$100,000 was paid to both Mr. and Mrs. Thompson, each must have received *some* money from the settlement and consequently the requirement they exhaust the liability limits before pursuing an underinsured motorist claim had not been fulfilled. If this were not the case, then there

could not have been any valid consideration given in exchange for the release of Mrs. Thompson's loss of consortium claim.

The Supreme Court of Georgia reversed the Court of Appeals. The Court determined that Mrs. Thompson's loss of consortium claim was entirely derived from Mr. Thompson's bodily injury claim and that she was not entitled to recover in excess of her husband's bodily injury claim from the liability insurance carrier. If the liability limits are 25/50, then the coverage limit is \$25,000 for *both* the bodily injury claim and loss of consortium claim. Therefore, the Court decided that the release signed by the Thompsons was ambiguous because it was unclear whether Mrs. Thompson actually received any of the liability carrier's limits in settlement. The Court further remarked that payment to her husband for his bodily injury claims could be valid consideration for her release of the loss of consortium claim.

The case was returned to the Court of Appeals which reluctantly adopted the opinion of the Georgia Supreme Court. In doing so, the Court of Appeals noted that the Supreme Court had overlooked the fact that Mrs. Thompson *also* asserted a personal injury claim and signed documentation that she intended to release these claims in addition to her loss of consortium claim. The Court of Appeals also remarked that the Supreme Court's act of overruling prior case law that prevented the use of parol (oral) evidence to narrow the clear, unambiguous language of a release will likely lead to post-settlement collusion.

UNINSURED MOTORIST COVERAGE/PHANTOM VEHICLE: Numerous witnesses were sufficient to corroborate existence and responsibility of unknown vehicle involved in three-vehicle traffic accident even though no physical contact occurred between unknown vehicle and other vehicles in accident.

State Farm v. Nelson, et al., 2009 WL 331635 (Ga.App.), decided February 12, 2009

Matthew Muldoon was driving directly behind another vehicle. The vehicle swerved around the vehicle ahead of it, which was turning left. Muldoon did not have time avoid the left-turning vehicle ahead of him and struck the rear of that vehicle, in which Cyrus Nelson was a passenger. Several witnesses saw the unknown vehicle swerve around the left-turning

vehicle, leaving Muldoon's vehicle with no time to avoid hitting the left-turning vehicle. Nelson was killed in the accident.

Nelson's parents filed a complaint for wrongful death against Muldoon and John Doe. The case went before a jury, which awarded plaintiffs \$1,106,165.02 and found that Muldoon

was ten percent negligent and John Doe driver was ninety percent negligent. State Farm appealed, arguing among other things that a non-striking vehicle (also referred to as a “phantom” vehicle in much of the case law) cannot be held liable for a motor accident under Georgia law and that, where there was no evidence of negligence on the part of the plaintiff driver, it was error for the trial court to instruct the jury that a rear-end collision does not automatically equate to negligence on the part of the driver of the striking vehicle.

The Court of Appeals found that the evidence was sufficient to corroborate the existence and responsibility of a phantom vehicle involved in the accident and that the jury charges were authorized.

OCGA § 33-7-11, the uninsured motorist statute, provides that in order for an insured to

recover damages as a result of the acts of an uninsured motorist, there must be actual physical contact between the phantom vehicle and the person or property of the insured. Such physical contact is not required, however, “if the description by the claimant of how the occurrence occurred is corroborated by an eyewitness to the occurrence other than the claimant.” OCGA § 33-7-11(b)(2).

The Court of Appeals affirmed the trial court’s judgment in favor of the plaintiffs and found that the evidence was sufficient to corroborate the existence and responsibility of a phantom vehicle involved in the three-vehicle traffic accident, and thus the automobile insurer could be liable for UM benefits for that proportion of damages caused by the unknown driver’s negligence, even though no physical contact occurred between the phantom vehicle and any other vehicle involved in the accident.

Florida Workers’ Compensation

One-Time Change in Physician

Providence Property & Cas v. Wilson, 990 So. 2d 1224 (Fla. 1st DCA 2008)

The claimant suffered a compensable back injury on August 26, 2005 and the employer/carrier authorized treatment. Subsequently, one of the physicians in the clinic prepared an office note, indicating that the claimant was being discharged and released on full-duty status, with no restrictions assigned. The doctor also stated that no future treatment was anticipated.

The claimant attempted to obtain additional treatment from the clinic approximately one year later and was advised that his case had been closed, and that he was no longer entitled to receive medical care under workers’ compensation. He then sought a one-time in authorized treating physicians, pursuant to §440.13(2)(f), Florida Statutes.

The employer denied the one-time change request, arguing that the compensable accident was no longer the major contributing cause of the claimant’s need for treatment for his back and he was not in the course of treatment at the time he made the request for a one-time change.

The Judge of Compensation Claims awarded the claimant the one-time change and the employer appealed that decision. On appeal, the Court affirmed the judge, holding that the statutory right to a one-time change is mandatory, regardless of whether the initial authorized physician opines that a compensable accident is no longer the major contributing cause of a claimant’s need for medical care. The Court noted that if after authorizing the one-

time change, the employer are still of the opinion that the treatment recommended or provided is unnecessary, or unrelated to the industrial accident, then they could deny authorization for such treatment, pending resolution of the issue by the judge.

As to employer's second defense that the one-time change request was made at a time when the claimant was no longer under the course of medical care, the Court held that the

claimant had begun receiving treatment from an authorized physician and the physician had evaluated the claimant and rendered a diagnosis during the provision of that treatment. That the originally authorized physician ultimately discharged the claimant from his care was irrelevant and the request for a one-time change was deemed to have been made during a time when the claimant was still in the course of receiving medical care.

Sunbelt Healthcare v. Galva, 34 Fla. L. Weekly D464; 1 DO-1336, February 27, 2009

The carrier was initially operating under a managed care arrangement that was discontinued as permitted by Florida Statute. During the time the claimant was receiving benefits under the managed care arrangement, he had sought and been granted alternative orthopedic care for about four years. After the carrier discontinued the managed care program, the claimant filed a Petition for Benefits seeking a change in physicians.

On appeal, the Court held that the benefit provided in §440.13(2)(f) is a claimant-initiated one-time change of physicians, the substantial equivalent of which the claimant in

that case received by selecting the alternative orthopedic physician, while under the managed care arrangement. The means of identifying and selecting the alternative physician, whether by claimant's choice (managed care) or by the employer pursuant to 440.13(2)(f), is a procedural mechanism in which a claimant has no vested substantive right. Because the claimant received substantial equivalent of a change in physicians contemplated by 440.13(2)(f) while she was under the managed care arrangement, there was no legal basis by which to award a (second) one-time change in orthopedic physicians.

Temporary Permanent Total Disability

Florida Transport 1982, Inc. v. Quintana, 1 So. 2nd 388 (Fla. 1st DCA 2009)

Claimant sustained a compensable chemical burn on his left foot, received treatment for the injury, reached physical maximum medical improvement, and was paid 104 weeks of temporary indemnity benefits. However, the claimant developed psychiatric difficulties and requested treatment. The employer authorized a psychiatrist to provide medical care, but the claimant declined to attend the appointment and requested a list of three new psychiatrists. Both parties obtained psychiatric IMEs, which were consistent in that the claimant was determined to need psychiatric

care and treatment, and was not at psychiatric MMI.

The judge, relying on *Emanuel v. David Piercy Plumbing*, 765 So. 2d 761 (Fla 1st DCA 2000), found the claimant should receive "temporary" PTD benefits. The judge based the PTD award solely on the claimant's psychiatric condition, as the claimant's psychiatric expert testified that the claimant was not capable of working from a psychiatric perspective at the time of the examination. The judge also found that the employer had authorized psychiatric treatment, but the claimant requested a one-

time change in authorized treating physicians, and because the employer had only offered one physician, was entitled to the offer of two more physicians from which to choose.

On appeal, the Court reversed as to the award of PTD benefits, as well as the separate award of psychiatric care. The claimant was at statutory MMI because he had received 104 weeks of temporary indemnity benefits, thus the claim for PTD benefits based on his physical condition alone could be made. However, the judge had declined to address whether or not the claimant was PTD based solely on his physical injuries. The judge's reliance on *Emanuel* to award temporary PTD benefits was in error, because *Emanuel* did not authorize temporary PTD benefits. To the contrary, *Emanuel* dealt with a claimant who had reached MMI from the only injury attributable to the accident and qualified for PTD benefits at that time. He later underwent a total knee replacement and could return to work after that, so PTD benefits were

awarded for a "temporary" period between MMI and his release to return to work. In the instant case, the judge also erred because the record contained no competent, substantial evidence to support the judge's award of PTD benefits based on the claimant's psychiatric condition alone.

As for authorization of two more physicians from which to choose a doctor for psychiatric care, the Court held that §440.13 was procedural and therefore, the law in effect at the time of the request applied. Under the 2005 version of Florida Workers' Compensation law, the employer was no longer statutorily required to provide the claimant with a choice of three physicians. In order to be entitled to a change in physicians, the claimant had to avail himself of the treatment authorized. In this case, the claimant refused to go to the psychiatrist the employer had authorized, therefore he is not entitled to receive a change in physicians until he has received medical care from the physician already authorized by the employer.

Attorneys' Fees – Plaintiff

Lanza v. Damian Carpentry, Inc., 34 Fla L. Weekly D574, 1 D08-2971, March 13, 2009

The claimant was injured in an accident that occurred on December 21, 1999. The claimant hired an attorney who filed a Petition for Benefits in 2004. The employer denied provision of all benefits based on the expiration of the statute of limitations. Settlement negotiations took place, at which time The attorney made a demand for settlement of the claim for \$17,500, inclusive of fees and costs, which the employer accepted.

After the parties reached settlement, the attorney provided a "breakdown" of the settlement funds to the employer. It requested that the employer create settlement documents reflecting a settlement of \$11,750, with a \$10,000 payment to the claimant, of which \$1,750 was to be designated as a statutory attorney's fee. the attorney asked the employer to draft a separate Stipulation for fees paid by the employer in the amount of \$5,750. At no time prior to reaching settlement, did the attorney discuss a separate Stipulation for fees to be paid by the employer.

As the attorney did not secure any benefits for his client, the employer did not agree to draft the settlement documents in the manner requested. He then requested that the employer rescind their statute of limitations defense to give the appearance that he obtained benefits and provide justification for a fee payable to him by the employer. The adjuster refused and sent \$17,500 to the attorney, stating that he was free to reach an agreement with his client for any fees he desired.

The employer then filed a Motion to Enforce the Settlement Agreement. The judge held two hearings on that Motion. the attorney did not attend the first hearing due to a family medical issue. The first hearing was continued to ensure his personal attendance, and for the rescheduled hearing. He opted instead to send an associate, who informed the judge that, due to medical reasons, it was impossible for the attorney to appear in person. The judge called the attorney and informed him that the hearing would be rescheduled at a time when he could personally attend. The judge received a return

message from him that he did not care what the judge's plans were regarding the hearing.

The hearing proceeded without any evidence being introduced in opposition on the employer's assertion that the parties entered into an agreement settling the claim for \$17,500, inclusive of attorneys' fees and costs. The judge enforced the agreement and dismissed the claimant's case with prejudice.

On appeal, the Court affirmed and held that at the time the Settlement Agreement was reached the claimant was responsible for

payment his of attorney fees and costs, and the claimant's demand for settlement was for a sum certain to include fees and costs. Once those terms were established, under no interpretation of the agreement would the employer have to pay an amount greater than \$17,500 to fully settle all claims, whether raised by the claimant or his attorney. Thus, the amount of the attorney's fee was a nonessential term of the agreement. His later attempts to secure a self-serving "breakdown" were new offers to settle additional matters that could be rejected without nullifying the original agreement.

Attorneys' Fees – Defense

Altstatpt v. Florida Dept. of Agriculture, 1 So. 3d 1285 (Fla. 1st DCA 2009)

Claimant sought review of an Order denying his Motion to Approve Defense Attorneys' Fees, by which he sought to require the Employer/Servicing Agent to seek the approval of the judge on attorneys' fees payable by the Employer/Servicing Agent.

On appeal, the Court held that §440.105(3)(c), Florida Statutes (2008), upon which the claimant relied for his Motion, did not

require approval of attorneys' fees by the judge; rather it merely made it unlawful to receive a fee unless that fee had been approved. As the claimant had sought approval of the fees by the judge, the Court found it unnecessary to decide whether the legislature intended for §440.105(3)(c) to apply to requests for payments made by attorneys representing employers, carriers and servicing agents, as well as those made by attorneys representing claimants.

Res Judicata

M.D. Transport v. Paschen, 996 So. 2d 902 (Fla 1st DCA 2008)

Claimant filed a Petition for Benefits for psychiatric care based on a letter from his authorized treating physician that recommended such care. Claimant also testified about his psychiatric problems during his deposition.

A Final Merit Hearing was held on claims involving an earlier filed Petition, but no reference was made to the Petition that requested psychiatric treatment. That 2004 Petition requesting authorization of psychiatric care had previously been scheduled for mediation that was to take place after the April 2005 Final Hearing. At a subsequent Final

Hearing on the claim for psychiatric care, the employer argued that the claim was barred on the grounds of res judicata, not being brought up during the April 11, 2005 Hearing.

The judge concluded the claim was not barred, because the Petition had not mediated by the time of the April 11, 2005 Final Hearing and thus, was not ripe. The judge further found that, because the employer had knowledge of the claim for psychiatric treatment, it was barred from asserting res judicata.

On appeal, the Court held that, while workers' compensation matters can result in numerous Hearings related to a single accident and injury, the parties cannot simply ignore outstanding issues when attending Final Hearings. The judge confused ripeness with procedures for getting an issue before the judge for adjudication. The claim for psychiatric care was ripe in 2002, when the claimant's authorized treating physician wrote the letter recommending psychiatric treatment. Failure to mediate the Petition before the April 11, 2005 Final Hearing did not preclude the application of res judicata. When a claim is ripe, absent some action on the claimant's part to bring the matter

to the attention of the judge, res judicata will bar a subsequent claim.

The Court held that the claimant had a number of options available to him, including seeking a waiver of the requirement to mediate, continuing the April 11, 2005 Hearing until after the scheduled mediation, securing a record stipulation from the employer that mediating the Petition was not necessary, or request that the judge retain jurisdiction on the issue. The claimant's failure to take any action barred him from subsequently litigating entitlement for authorization of psychiatric care.

South Carolina Coverage

INSURANCE COVERAGE/CAUSE OF LOSS: Under water damage exclusion and anti-concurrent causation clause of homeowners' policy, loss was excluded from coverage.

South Carolina Farm Bureau Mutual Insurance Company v. Durham, 380 S.C. 506 (S.C.), decided January 12, 2009

South Carolina Farm Bureau Mutual Insurance Company ("Farm Bureau") filed a declaratory judgment action seeking a declaration that its policy did not cover the damage to the Durhams' swimming pool after the Durhams drained the pool and it "floated."

Farm Bureau asserted that two policy exclusions prevented coverage under the policy. The first exclusion concerned water damage to a swimming pool caused by cracking or settling of a foundation or ground. The second exclusion concerned water damage from water below the surface of the ground which leaks through a swimming pool.

The parties stipulated to the facts and submitted the case to the circuit court. The circuit court held that the policy covered the damage and Farm Bureau appealed.

The South Carolina Supreme Court determined that the case involved a novel question of law in South Carolina as the issue was what "caused" the pool to float. "Cause" was not defined in the policy.

"Cause" in the context of an insurance policy is not the same as legal or proximate causation. Rather, cause is something that produces an effect, result or consequence, and therefore the "but for" test is the proper test for causation under an insurance policy.

There are two main tests for determining coverage where the loss is the result of multiple causes. The majority rule follows the "efficient proximate cause doctrine," which provides that in circumstances with two or more identifiable causes, the court looks to the cause that is determined to have set the chain of events in motion. If this "efficient proximate cause" is

covered under the terms of the policy, then the loss is covered. The minority rule is the “concurrent cause” rule, which considers whether one of the causes of a loss is covered. If so, then the loss is covered, notwithstanding the fact that there is also an excluded cause in the chain of causation.

In this case, *neither* test applied because the policy contained an anti-concurrent causation clause. This clause provided that any loss excluded under the policy “is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss.” Therefore, the exclusion applied if there was *any* excluded cause of loss.

South Carolina Workers’ Compensation

WORKERS’ COMPENSATION/PSYCHOLOGICAL INJURY: Claims for psychological injury are compensable only if claimant proves by preponderance of evidence that psychological injury was caused by physical injury or extraordinary and unusual conditions of employment.

Pack v. Department of Transportation, 2009 WL 348894 (S.C.App.), decided January 27, 2009

Claimant Pack worked as an assistant with the asphalt crew for the South Carolina Department of Transportation (DOT). She later began working with the roadside herbicide application crew. She suffered serious injuries due to inhalation of herbicide.

The single commissioner determined that Pack had not reached maximum medical improvement and had suffered brain injury. The Appellate Panel affirmed the decision with amendments. The majority of the Appellate Panel held that Pack’s injuries were limited to the respiratory system with a psychological overlay but that she did not have a brain injury. The circuit court reversed the Commission, finding that Pack had suffered a brain injury, and affirmed the findings as to the respiratory and psychological injury.

Claims for psychological injury are compensable only if the claimant proves by a preponderance of evidence that they are caused by physical injury or by extraordinary and unusual conditions of employment. In this case, the Court of Appeals noted there was no contention that Pack’s injuries were related to extraordinary and unusual conditions of

employment, and therefore Pack was required to prove a physical injury.

The Court of Appeals held that there was not enough evidence in the record to establish whether Pack’s psychological injury was related to her respiratory injury or her brain injury. The court therefore remanded the issue to the Commission to make findings as to the causal link between Pack’s physical injuries and her psychological injuries.

WORKERS' COMPENSATION/UNINSURED EMPLOYERS' FUND: Liability was not transferred to Fund where subcontractor's certificate of workers' compensation insurance was unsigned.

Barton v. Higgs, 2009 WL 294788 (S.C.), decided February 9, 2009

Claimant David Barton was employed by Iyanel Enterprises, a subcontractor to Total Home Exteriors. Claimant sustained a compensable injury when he fell from a roof. At the time of the accident, Iyanel did not have workers' compensation insurance and Total Home was liable to pay Claimant benefits. Total Home sought to transfer its liability to the Uninsured Employers' Fund pursuant to S.C. Code Ann. § 42-1-415.

The case was heard by the single commissioner. Total Home's president testified that he received a certificate of insurance from Iyanel showing that Iyanel had a workers' compensation policy in effect that covered the date of accident. The certificate showed Total Home as the certificate holder, but the certificate was not signed in the blank listed for "Authorized Representative" of the producing agency. Higgs testified that he paid for the insurance and that an employee of the insurer issued the certificate. Apparently, however, coverage was never bound, which resulted in Iyanel being uninsured on the date of accident.

The single commissioner held that Iyanel had attempted in good faith to obtain workers' compensation insurance and that Iyanel had presented the certificate of insurance to Total Home. The single commissioner found that liability should be transferred to the Fund. The full Commission, circuit court, and Court of Appeals affirmed the decision of the commissioner.

The Supreme Court reviewed the decision to transfer liability to the Fund and reversed, holding that Total Home failed to obtain the proper documentation of the alleged existence of workers' compensation insurance from Iyanel.

Under the Workers' Compensation Act, a general contractor is a "statutory employer" of the subcontractor's employees and is liable to pay workers' compensation benefits to a subcontractor's employee who is injured on the job pursuant to S.C. Code Ann. § 42-1-410. The purpose of the statute is to provide compensation for the injured employee and assure coverage. A general contractor may

transfer liability to the Uninsured Employers' Fund if the subcontractor provided the contractor with proof that the subcontractor has workers' compensation insurance.

In order to transfer liability to the Fund, the contractor must collect standardized documentation of the insurance from the subcontractor. The Commission promulgated a regulation, S.C. Code Reg. 67-415, which provides that a certificate of insurance shall serve as documentation of insurance and that the certificate "must be dated, signed, and issued by an authorized representative of the insurance carrier for the insured." Liability may only be transferred from the contractor to the Fund if the contractor has collected proper documentation of the subcontractor's claim that the subcontractor has workers' compensation insurance.