

# CALENDAR CALL

GENERAL PRACTICE AND TRIAL SECTION STATE BAR OF GEORGIA

Vol. XV

Spring 2008

No. 2



# SPRING



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Vol. XV

Spring, 2008

No. 3



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Calendar Call is the official publication of the General Practice and Trial Section of the State Bar of Georgia. Statements and opinions expressed in the editorials and articles are not necessarily those of the Section of the Bar. Calendar Call welcomes the submission of articles on topics of interest to the Section. Submissions should be double-spaced, typewritten on letter-size paper, with the article on disk or sent via e-mail together with a bio and picture of the author and forwarded to James W. Hurt, Jr., Winburn, Lewis & Stolz, LLP, 279 Meigs Street, Athens, GA 30601, jimmyhurt@Charter.net **Published by Appleby & Associates, Austell, Georgia.**



Fellow members of the bar, I am very pleased and proud to serve as the Chair of the General Practice and Trial Law Section of the State Bar of Georgia this year. As the largest section of the State Bar, we serve a strong leadership role in the State Bar. There cannot possibly be a more important time to be a lawyer. As our profession comes under attack through tort reform and other measures, I reflect on the good things that lawyers do and why we do them.

We all go into law for many different reasons, but one of the themes that carries through our profession is service. One cannot be a member of our profession and not have the personality or talent for service. It seems that everyone has a story of service that influenced our choice of profession. Mine comes from a single mother raising children, barely making ends meet, but always finding something extra to help those in need. Two teenage boys got into trouble for what they thought were pranks, but were felonies, and one the son of a doctor who could afford a lawyer escaped punishment, but the poor child from the federal housing project who could not afford a lawyer could not escape punishment. So, this same mother called every lawyer in the local community and finally convinced a local lawyer the night before the trial to help the poor teenage boy for \$50 down and \$50 a month. That lawyer had no reason to help in this situation, certainly not for the fee, but he

did so because it was the right thing to do—to provide this service. And once the case was over, he severely reduced his bill so it could actually be paid in months, not years. This type of service is not highly publicized, but it happens every day in obvious and not so obvious ways.

Attorneys serve the rule of law and justice in our society every time we act in a professional manner or serve a client. The lawyers in the trenches of the courtroom every day serve to keep our system functioning. We believe we can restore justice to the world and right the wrongs our clients have suffered. The fight itself proves our contribution to society, whether we win or lose. Victories, small and large, prove our worth to the system. No matter the amount or extent of the victory, the satisfaction is there. Victories come in many ways. The rule of law and society are served when a child is saved from further abuse, when a pension is restored that was wrongfully withheld for the retiree, when sufficient funds are obtained for repairs to be done to a client's home in a negligent construction case, when a client is reinstated to gainful employment, when an award is secured for a client who has suffered sexual discrimination or racial slurs, or when the jury awards sufficient funds for an injured client to be cared for during the rest of his life.

The member of the General Practice and Trial Law Section also serve our clients in quieter ways. We draft wills and financial powers of attorney to protect our clients before

they need the protection. We handle adoptions, pre-nuptial agreements, and traffic tickets. We draft contracts, provide advice on the enforceability of contracts, we advise clients how to get their cars out of the shop or refunds of money when the repairs have gone awry. In myriad ways, large and small, we impact the lives of our clients.

We get to know our clients. We become their friends. We empathize with them. We suffer with them through their case, their trials, and their emotional crises. We suffer as much (and sometimes more) than do our clients when we are not successful in obtaining a favorable result for our client. However, as professionals, we stay above the fray and try not to be personally involved. It's a very difficult role we play. Yet, we continue to come back every day and fight for those who cannot fight for themselves. And that is why many chose our profession.

Of course, there are those who

would say we do not truly provide service because we are compensated for the legal services we do provide. And there are those who begrudge our collection of fees particularly when an attorney achieves a significant fee in a case, but you rarely hear that of other professions, likely because of our fee structures. But our very fee structures allow access to justice for those who could not otherwise afford it. Our compensation comes in the form of fees, of course, but also in goodwill for our profession and self-satisfaction that we have contributed to the rule of law and society through our roles as advocates.

Our members also serve by actively participating in bar leadership, in bar projects and on bar committees. We organize and speak at seminars. Some attorneys write articles, such as those that appear in this issue of Calendar Call, to help other members of our profession. Many attorneys devote untold hours to provide pro bono service. We monitor and suggest leg-

islation. Attorneys support and participate in charity work from helping to plant flowers to contributing thousands of dollars.

I want to encourage all of us to become more involved in our professional organizations. Join a committee, take a pro bono case, volunteer on a service day, write an article for the next issue of this publication. Support professionalism in the way you deal with judges, clients, and, yes, opposing counsel. Participate in the mentoring program through the Supreme Court or at the law school nearest you.

Some may think this is an idealistic view of our profession, especially in these difficult times. Perhaps it is idealistic, but it is also an accurate view of the service aspects of being an attorney. I am proud of our profession and proud to be a member of the profession. Our profession is only as strong as we make it. Let's endeavor to be active professional members and continue to serve as members of the bar have historically done. ■

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# Beware, Cross-Claims are not Always Permissive

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*He is actively involved in the State Bar of Georgia, serving on the Board of Governors since 2004. He is a Board Member and District Representative of the General Practice and Trial Section, and was elected as the Treasurer/Secretary of the Section in 2007. On August 1, 2007, Pope Langdale was appointed to the Unlicensed Practice of Law District 2 Committee by the Supreme Court of Georgia. Pope has served on the legislative and membership committees of the Georgia Trial Lawyers Association (GTLA), to which he was recently elected as a District Vice-President.*

*Pope is also a member of the Southern Trial Lawyers' Association (STLA), the American Association of Justice, the American Bar Association, and serves as a Fellow of the Lawyer's Foundation of Georgia, a non-profit arm of the State Bar of Georgia. He serves as special master under the Supreme Court of Georgia in lawyer discipline cases and was appointed by the Lt. Governor to serve on the committee to select the public defender for the Southern Judicial Circuit.*

*Pope primarily practices in the area of civil litigation, representing injured victims, as well as individuals and businesses involved in commercial litigation.*

Most of us have thought that cross claims are always permissive. Unfortunately they are not. There are times in which they are compulsory, and such a time occurs when a defendant in a lawsuit has a potential cross-claim against a co-defendant for injuries received from the same incident as the main claim. This can be a very dangerous situation for both plaintiff's attorneys and insurance defense counsel who are not aware that their defendant client, who was injured in some incident, but who has subsequently been sued contending that they were jointly responsible with another defendant, must file a cross-claim in the action in order to preserve the defendant's personal injury cause of action. This is an easy

situation to overlook, especially since most attorneys would prefer to wait until the first action concludes, because the defendant (client) can have a cleaner case as the plaintiff, instead of a cross-claiming defendant.

The purpose of this article is to make all practitioners aware that cross claims are not always permissive, and there are circumstances which mandate a cross claim be filed, or there will be the risk of it being barred by res judicata. This is especially important for plaintiffs' attorneys who are representing a client who subsequently becomes a defendant in a lawsuit arising out of the exact same occurrence which your client claims he/she is injured. Most often, these claims are defended by

insurance counsel, and the insurance counsel's primary duty is defending your client in that lawsuit. Many plaintiffs' attorneys do not realize that they must come in as an attorney of record and actually file the cross claim against the co-party defendant at that time, or it is likely going to be barred in a subsequent litigation by the doctrine of res judicata.

The Supreme Court of Georgia seems to have first established compulsory cross-claims in *Citizens Exchange Bank of Pearson v. Kirkland*<sup>1</sup>. Since then, the appellate courts have since consistently held that while cross-claims are usually considered permissive, not compulsory, when a co-defendant does not assert a cross-claim arising out of the same incident

against a co-defendant, it will bar a subsequent claim<sup>2</sup>. Furthermore, “[R]es judicata bars a party who forgoes an opportunity to file a permissive cross-claim from bringing the claim in a subsequent action.”<sup>3</sup>

In *Kirkland*, *supra*, an estate brought suit against a bank for negligent advice that resulted in a certificate of deposit being paid to a decedent’s widow, rather than to the estate. In a prior suit, the widow had sued the estate and the bank, seeking a declaratory judgment that she was entitled to the CD.<sup>4</sup> A default judgment for the widow had been entered in the action based on the estate’s failure to answer, and on the bank’s representation to the court that it was a “neutral party.” The Supreme Court held that this judgment constituted a bar to the estate’s subsequent negligence suit against the bank, finding that the claim against the bank should have been raised as a cross-claim in the declaratory judgment action.<sup>5</sup> The Supreme Court stated that “a judgment on the merits is conclusive as to all matters, which were or could have been put in controversy between identical parties or their privies in identical causes of action. (citations omitted) Mrs. Kirkland, the plaintiff here, could have raised the issue of her co-defendant’s negligence by way of a cross-claim in the previous action.”<sup>6</sup> Although not in the context of a personal injury claim, the *Kirkland* court clearly established that *res judicata* will bar a subsequent action that could have been filed as a cross-claim.

The Supreme Court of Georgia has thereafter consistently held that a party who forgoes an opportunity to file a permissive cross-claim in a prior action is estopped by the doctrine of *res judicata* from bringing the claim in a subsequent action.<sup>7</sup> “One must assert all claims for relief concerning the same subject matter in one lawsuit and any claims for relief concerning that same subject matter which are not raised will be *res judicata*.”<sup>8</sup>

For the doctrine of *res judicata* to apply, three requirements must be

met: (1) the prior action must have involved an adjudication by a court of competent jurisdiction; (2) the two actions must have an identity of parties and subject matter; and (3) the party against whom the doctrine of *res judicata* is raised must have had a full and fair opportunity to litigate the issues in the first action.<sup>9</sup>

(1) Adjudication by a Court of Competent Jurisdiction.

If the prior action is allowed to proceed to a final judgment, obviously there will be an adjudication by a court of competent jurisdiction. However, what must also be remembered is that a voluntary dismissal with prejudice is the equivalent of adjudication by a court of competent jurisdiction, and it is not necessary that a court actually render a judgment in the prior action to have been considered an adjudication.<sup>10</sup> Under Georgia law, “a dismissal with prejudice operates as an adjudication on the merits. It is a final disposition.”<sup>11</sup>

(2) Identity of Parties and Subject Matter.

Under Georgia law, “the term ‘party’ to an action includes all who are directly interested in the subject matter, and who have a right to make defense, control the pleadings, examine and cross-examine witnesses, and appeal from the judgment.”<sup>12</sup> Typically, defendants have a direct interest in the subject matter, and had a right to make a defense, but the courts will look to whether or not there is an adversarial relationship between the parties.

However, this is fairly easy, as *Restatement of Judgments 2d*, §38, provides that the necessary adversarial relationship between co-parties is satisfied where the claims or defenses in the pleadings put parties in an adversarial relation to each other, even though they may also be aligned together against a third party.<sup>13</sup>

Identity of subject matter is satisfied when it involves the same incident and ensuing injuries arise out of the same incident.

(3) Full and Fair Opportunity to

Litigate the Issues in the First Action.

There is essentially a four part test established in *Fowler*, *supra*, to determine whether or not the defendant had a full and fair opportunity to litigate the issues in the first action, and is more fully discussed below. Those four factors essentially center around whether or not the defendant could have filed the cross-claim, although he/she simply preferred not to do so, taking into consideration venue, whether or not the defendant had hired personal counsel concerning his own injuries, as well as the ways in which the inconvenience of being a defendant and filing a personal injury cross-claim could have been handled.

Typically, it is unlikely that the defendant was not allowed to file a cross-claim against the other defendant for personal injuries which he/she now contends to have received as a result of the incident. Thus a defendant will typically be held to have had an opportunity for a court to properly determine the merits of his/her case and his defenses in the prior action, had the cross-claim been filed.

### Authority of *Fowler* and *Suggs*

In *Fowler*, *supra*, the Supreme Court of Georgia squarely addressed the issue of whether Georgia’s codification of the rule of *res judicata*, found in O.C.G.A. § 9-12-40, should operate to bar a personal injury claim not brought previously as a permissive cross-claim under O.C.G.A. § 9-11-13.<sup>14</sup> For purposes of understanding the *Fowler* decision, and its importance, examination of the facts underlying the Supreme Court’s decision is necessary. *Vineyard* (a MARTA bus driver) and *Fowler* (the driver of the truck owned by Georgia Hi-Lift) were involved in a collision in which 26 persons were injured.<sup>15</sup> Two of the injured bus passengers filed separate actions against MARTA, *Vineyard*, *Fowler*, and Georgia Hi-Lift. *Vineyard* and MARTA filed cross-claims against the Hi-Lift defendants for contribution and indemnification, and subsequently all

*continued next page*

of the parties settled both passenger suits out of court, with Vineyard and MARTA voluntarily dismissing with prejudice their cross-claims against Fowler and Georgia Hi-Lift.<sup>16</sup> In this prior action, the attorney for MARTA represented both MARTA and Vineyard in the bus passenger suits, although Vineyard had retained other counsel to represent him individually with respect to his claims for personal injury. Vineyard's personal counsel did not want to assert Vineyard's claim for personal injuries in the prior action because he wanted to wait to determine the extent of Vineyard's permanent injuries. After the voluntary dismissal with prejudice of the prior action, Vineyard then sued Fowler and Georgia Hi-Lift for his own personal injuries sustained in the collision. The defendants moved for summary judgment based upon res judicata.

The Court in Fowler addressed each of the three requirements necessary which must be met in order for the doctrine of res judicata to apply under the factual scenario presented above. First, the court held that under O.C.G.A. § 9-12-40, the voluntary dismissal with prejudice, even without order or approval of the trial court, is considered a judgment on the merits for purposes of the res judicata statute.<sup>17</sup> Second, the Court held that there was a clear identity of parties and an identity of subject matter, finding that Vineyard had an adversarial relationship with Fowler and Georgia Hi-Lift in the prior litigation, and that the claims arose from the exact same subject matter - the accident between the bus Vineyard was driving and the truck Fowler was driving.<sup>18</sup> Third, the Supreme Court held that Vineyard had a full and fair opportunity to litigate his personal injury claim in the prior litigation, primarily based upon four factors: (1) Vineyard had employed his present attorney at the time of the first action and could have had his attorney assert his personal injury claim in such action; (2) Vineyard

could have filed his personal injury claim in the first action and asked the court for a continuance to permit him to gain more information regarding the permanency of his injuries; (3) if Vineyard perceived any prejudice that might have arisen from trying his personal injury claim in the context of the first action, he could move the trial court to separate that claim from the other claims in that action; and (4) the first action was not an inconvenient forum for Vineyard as his subsequent personal injury claim was filed in the same superior court as the first action.

Finally, in Fowler, the Supreme Court addressed Vineyard's argument that applying res judicata to defeat his personal injury claim would have the effect of making it a compulsory cross-claim which Vineyard contended would be inconsistent with the policy behind O.C.G.A. § 9-11-13(g).<sup>19</sup> Relying upon the Supreme Court's decision in Kirkland, the Court held, however, that Vineyard's argument fails as a matter of law because res judicata bars a party who foregoes an opportunity to file a permissive cross-claim from bringing the claim in a subsequent action. *Id.* Based upon Kirkland, the Supreme Court of Georgia held that Vineyard's personal injury action was barred by the doctrine of res judicata.<sup>20</sup>

The Fowler decision was recently followed in early 2006 in a Court of Appeals decision of Suggs v. Hale.<sup>21</sup> This is a decision in which our firm was asked to defend and in which the issue of res judicata was raised. As in Fowler, the facts underlying the incident giving rise to the personal injury claims of Plaintiff Suggs are important to understand. Suggs and Hale were involved in a vehicle collision on December 31, 2001. Suggs and Hale were both drivers of separate vehicles. Hale alleged that as he began to pass Suggs, Suggs made a maneuver towards the center of the roadway in an effort to prevent the passing, forcing Hale onto the shoulder, which ultimately caused Hale's vehicle to flip over which re-

sulted in the ejection of a passenger riding with Hale. The passenger in Hale's vehicle was killed. Suggs and Hale were both sued as defendants in a wrongful death action on behalf of the passenger's heirs, which was defended by the insurance carriers for Hale and Suggs, respectively. In this prior action, Suggs and Hale each alleged that the other was responsible for the passenger's death. Nevertheless, at a mediation, the insurers, on behalf of both Suggs and Hale, contributed to a joint settlement with the heirs of the passenger's family. The settlement agreement was entered into by the insurers, and indicated that the insureds did not consent to the settlement.<sup>22</sup>

Subsequently, Hale brought a separate action against Suggs for injuries he sustained in the collision. Suggs, based upon the authority of Fowler, filed a Motion for Summary Judgment claiming that Hale was barred by the doctrine of res judicata from asserting such claim now in a separate action, and that he should have filed his personal injury claim as a cross-claim in the action involving the death of the passenger in Hale's vehicle. The trial court denied summary judgment, but the Georgia Court of Appeals, relying primarily upon Fowler and Majestic Homes, reversed the trial court and entered summary judgment on behalf of Suggs.

At the appellate level, Hale conceded that both the parties in the cause of action were identical in both cases, but argued that res judicata should not apply for two reasons: (1) there was neither a complete adjudication on the merits, nor (2) a full and fair opportunity to litigate the issues in the wrongful death action. Regardless of these arguments, based upon Fowler, the Court of Appeals held that neither argument barred the application of res judicata. It is important to understand some of the Court's reasoning. First, Hale asserted that res judicata should not apply because there was simply a voluntary dismissal with prejudice, and Hale's counsel in the wrongful

death action did not have authority to settle his case. The Court of Appeals disagreed and determined that even though Hale contended that his counsel in the wrongful death action (insurance defense counsel) did not have authority to settle his case, Hale could not challenge the validity of the judgment in this subsequent proceeding, and that the judgment that was entered binds Hale for purposes of res judicata.<sup>23</sup> Obviously, the importance of this holding is that insurance counsel representing a defendant can bind the defendant for purposes of res judicata, even though the insurance counsel is not typically hired in that scenario to represent that defendant in his/her personal injury claim arising out of the incident.

Secondly, the Court of Appeals held that Hale had a full and fair opportunity to litigate his personal injury claim, even though Hale contended that if he had done so, he would have been in a very hostile and unmanageable climate. Relying primarily upon Fowler, the Court held that Hale did in fact have a full and fair opportunity to litigate his

personal injury claim in the wrongful death action. The Court determined that he employed his present attorney within two weeks of the collision, well before the wrongful death action was filed. To the extent that Hale had ongoing medical expenses, he could have brought his claim and requested a continuance, and, Hale could have moved to separate his claim if he believed he would be prejudiced by trying it together with the wrongful death claim. Finally, the forum (venue) was convenient to Hale in both the wrongful death action and his subsequent personal injury action, as both were filed in the same county. In conclusion, Suggs held that “although he did not avail himself of it, Hale had a full and fair opportunity to litigate his personal injury claim in the wrongful death action”, and “because Hale did not bring a cross-claim for his personal injuries in the prior wrongful death action, res judicata bars him from bringing a separate claim now.”<sup>24</sup>

In summary, a defendant, who could have filed a cross-claim against another co-defendant, but does not

do so, electing instead to settle the main action in exchange for a full release and dismissal, and then file a personal injury action against the co-defendant, will likely find themselves barred by the doctrine of res judicata. Certainly you cannot allow a voluntary dismissal with prejudice to be entered for your client, because regardless of the fact that your client does not consent to the settlement, it is going to, under Fowler and Suggs, be considered a bar to any subsequent action for your client’s injuries as a result of the doctrine of res judicata. Insurance defense counsel must also be prepared to explain to their clients (defendants) the ramifications of a settlement if the client also has a claim for injuries arising out of the same occurrence. ■

## FOOTNOTES

<sup>1</sup> 256 Ga. 71 344 S.E. 2d 409 (1986)

<sup>2</sup> Stringer v. Bugg, 254 Ga. App. 745, 747, 563 S.E.2d 447 (2002); Suggs v. Hale, 278 Ga. App. 358, 629 S.E.2d 11 (2006), cert. denied; Majestic Homes v. Sierra Dev. Corp., 211 Ga. App. 223, 225, 438 S.E.2d 686 (1993); Fowler v. Vineyard, 261 Ga. 454, 405 S.E.2d 678 (1991)

<sup>3</sup> Stringer, supra at 747

<sup>4</sup> supra at 71

<sup>5</sup> Id. at 71

<sup>6</sup> Id. at 71

<sup>7</sup> Fowler, supra; Stringer, supra; Majestic Homes, supra; and Kirkland, supra

<sup>8</sup> Kaylor v. Rome City Sch. Dist, 267 Ga. App. 647; 600 S.E.2d 723 (2004)

<sup>9</sup> See Majestic Homes, supra

<sup>10</sup> Hedquist v. Merrill Lynch, Pierce, Fenner & Smith, Inc., 272 Ga. 209, 212, 528 S.E.2d 508 (2000)

<sup>11</sup> Marchman & Sons, Inc. v. Nelson, 251 Ga. 475, 306 S.E.2d 290 11 (1983); Fedeli v. UAP/GA.AG.Chem., Inc., 237 Ga. App. 337, 342, 514 S.E.2d 684 (1999).

<sup>13</sup> Kaylor v. Rome City Sch. Dist., 267 Ga. App. 647; 600 S.E.2d 723 (2004)

<sup>14</sup> See also Fowler, supra

<sup>15</sup> Id. at 455

<sup>16</sup> Id. at 454

<sup>17</sup> Id.

<sup>18</sup> (citing Rowland v. Vickers 233 Ga. 67, 209 S.E.2d 592 (1974), and Marchman & Sons v. Nelson, 251 Ga. 475, 306 S.E.2d 290 (1983)

<sup>19</sup> Id. at 457-458

<sup>20</sup> Id. at 459

<sup>21</sup> Id.

<sup>22</sup> 278 Ga. App. 358, 629 S.E. 2d 11 (2006), cert. denied, 2006 Ga. Lexis 689 (2006)

<sup>23</sup> Id. at 358

<sup>24</sup> Id. at 359

# Can Plaintiffs' Attorneys Designate Settlement Proceeds as Pain and Suffering to Circumvent Claims for Medicaid Reimbursement in Georgia?

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*Fred M. Valz concentrates his practice in the defense of businesses and individuals in civil lawsuits, including business and commercial litigation and defense in all areas of tort litigation. Fred further handles numerous cases involving insurance coverage disputes and bad faith litigation. He has spoken at numerous legal and claims seminars throughout the United States and has published several articles on tort insurance law and insurance coverage.*



*Liza Carter focuses on insurance coverage and bad faith litigation, primarily in the areas of transportation, including auto and motor carrier liability, and premises liability. Liza was research assistant to Dean Samuel M. Davis at the University of Mississippi School of Law. She participated in the University of Mississippi Civil Legal Clinic Juvenile Advocacy Clinic and was a member of the Dean's List.*

On May 1, 2006, the United States Supreme Court decided *Arkansas Dept. of Health and Human Services v. Ahlborn, supra*, which could greatly impact claims for reimbursement of Medicaid benefits in Georgia. Arguably, after *Ahlborn*, the Georgia Dept. of Community Health's claims for reimbursement of Medicaid benefits paid applies only to recoveries designated as medical expenses, and not to recoveries designated as pain and suffering. At issue is Georgia's interpretation of the Federal Medicaid Act (U.S.C. §1396) in regard to whether a state may assert a lien upon the entire proceeds of a recovery against a third-party to fully recoup all amounts expended on a medical care recipient or a state may only assert a lien upon those proceeds designated as "medical expenses." The Federal Medicaid Act requires that states participating in the Medicaid program do the following:

1.

"Ascertain the legal liability of third-parties...to pay for [an individual benefits recipients'] care and services available under the [State's] plan." (§1396a(a)(25) (A))

2.

Enact "laws under which, to the extent that payment has been made... for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or

services. (§1396a(a)(25)(H))

3.

to “provide that, as a condition of [Medicaid] eligibility...the individual is required...(A) to assign the State any rights...to payment for medical care from any third party...(B) to cooperate with the State...in obtaining such payments ...and... (C)...in identifying and providing information to assist the State in pursuing, any third-party who may be liable.” (1396k(a)(1))

4.

“any amount collected by the State under an assignment made” as described above “shall be retained by the State...to reimburse if for [Medicaid] payments made on behalf of” the recipient. Acting pursuant to the Medicaid statute, Georgia enacted O.C.G.A. §49-4-149, which gives the Georgia Dept. of Community Health a lien upon all money or property a medical assistance recipient or his legal representative receives as a result of that recipient’s “sickness, injury, disease, disability or death, due to the liability of a third-party” which caused the recipient’s need for medical care. (O.C.G.A. § 49-4-149(a)). However, the Department is only subrogated to the “extent of the reasonable value of the medical assistance paid and attributable to any sickness, injury, disease, or disability”. (O.C.G.A. § 49-4-149(c)). Additionally, an assignment of the rights to receive payment from a third-party is made when the medical assistance recipient receives medical care for which the Dept. of Community Health may become responsible for paying. The amount of that assignment is “up to the amount of medical assistance actually paid by the department.... (O.C.G.A. 49-4-149(d)). The Supreme Court of Georgia interpreted the above Georgia statute in the case of, *Richards v. Georgia Dept. of Community Health*, 278 Ga. 757, 604 S.E.2d 815 (2004). *Richards* involved a class-action suit brought against the Georgia Dept.

of Community Health (“GDCH”) by Medicaid recipients whose tort recoveries had been used to reimburse the GDCH and those Medicaid recipients whose tort recoveries had not yet been used. *Richards*, 278 Ga.App. at 758, 817. *Richards*, one of the plaintiffs in the case, alleged that Georgia Dept. of Community Health’s application of O.C.G.A. §49-4-149 was in error, because he alleged O.C.G.A. § 49-4-149 (d)1 only allowed recovery to the extent of the portion of the recovery designated for medical expenses/treatment. *Id.* at 818, 759. However, the court held that GDCH’s practice under §49-4-149 is to assert a lien upon all proceeds of a recovery, not just upon the portion classified as proceeds for medical expenses. *Id.* The court found that this interpretation was consistent with federal law. *Id.* The court stated “[t]he Medicaid statute is intended to vest States with the right to recover the full payment of medical expenses by a third-party liable for causing the injuries which triggered the need for medical care.” *Id.* (quoting *Ahlborn v. Arkansas Dept. of Human Svcs.*, 280 F.Supp. 881, 888 (E.D. Ark. 2003))2. The Court found that to adopt *Richard’s* view would “allow a Medicaid recipient to negotiate a tort settlement structured in such a way so as to reflect no or minimal compensation for medical expenses, or to convince a jury to create such structures, and thereby gain a recovery that does not require significant compensation to the taxpayers who funded his medical care.” *Id.* at 759-760.

In addition, *Richards* argued that GDCH’s lien violated 42 U.S.C.A. §1396 p(a)(1)3, the anti-lien provision. *Id.* at 760, 818. The court disagreed with *Richard’s* argument. The court found that there was no lien on the recipient’s property, because the minute the recipient received medical care, the statutory assignment occurred and the recipient assigned his recovery for the medical assistance actually paid by the state to the state

before he or she even received the proceeds for the tort recovery. *Id.* at 819, 760. However, the U.S. Supreme Court in *Arkansas Dept. of Health and Human Svcs*, *supra*, a case similar to *Richards*, directly contradicts *Richards’* conclusion. In *Ahlborn*, a 19-year old woman was injured in a car accident and the Arkansas Dept. of Health and Human Svcs. (“ADHS”) determined she was eligible for Medicaid assistance and paid \$215,645.30 of her medical expenses. *Ahlborn*, 126 S.Ct. at 1757. Ms. Ahlborn brought a tort claim for past medical costs, permanent physical injury, future medical expenses, past and future pain, against a third-party which she settled for \$550,000. *Id.* ADHS did not intervene in the settlement nor did it ask to participate. *Id.* ADHS did, however, assert a lien over the proceeds of the settlement. *Id.* The proceeds of the settlement were not allocated between the categories of damages, but ADHS and Ms. Ahlborn stipulated that Ms. Ahlborn only received 1/6 of the true value of her claims and the portion of the settlement recovered for medical costs amounted to \$35,581.47. *Id.* at 1757-1758. The ADHS contended they were entitled to the full \$215,645.30 they paid in medical costs according to Arkansas law. *Id.* at 1758. Pursuant to the Medicaid Act, the State of Arkansas enacted a law which stated that a Medicaid applicant “shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third-party [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.” *Id.* at 1759. This provision is similar to the statute the State of Georgia enacted.4 When the Medicaid recipient receives benefits from injuries suffered, ADHS, has “a right to recover from the person the cost of benefits so provided.” *Id.* In *Ahlborn*, the ADHS was not just trying to recover the \$33,581.47 portion of the recovery deemed to be for medical expenses, but was

*continued next page*

trying to recover the full \$215,645.30. *Id.* at 1758. For ADHS to recover the full value amount of the money expended, ADHS would have had to recover portions of the recipient's settlement deemed for other injuries. *Id.* at 1760. ADHS argued that it was entitled through the Arkansas Medicaid statute, to recover the full amount it expended. *Id.* The issue in the case was whether ADHS could "lay claim to more than the portion of Ahlborn's settlement that represents medical expenses." *Id.* The Supreme Court found ADHS could not. *Id.* The Supreme Court stated that the Federal "third-party liability provisions" focus on "recovery of payments for medical care...not rights to payment for lost wages, for example." *Id.* at 1761. ADHS argued that the language of §1396a(a)(25)(B)5 authorized the state to recover the full amount of the recipient's recovery if it is required to be fully reimbursed. *Id.* However, the Supreme Court found otherwise, stating that the language contained in §1396a(a)(25)(B) which states, "such legal liability" refers to "the liability of the third-parties...to pay for care and services available under the plan." *Id.* Thus, in *Ahlborn*, the Supreme Court found that where the tortfeasor only accepted liability for 1/6 of the overall damages and only \$35,581.47 was for medical damages, the "liability" which the state could be reimbursed from only extended to \$35,581.47, the amount the third-party was legally liable for the medical expenses. *Id.* The state can only recover up to the amount the third-party became legally liable to pay to for, for the medical expenses. In addition, ADHS also argued that the language contained in §1396(a)(25)(H)6 supported the argument that the State is allowed to recover the amount it paid on the recipient's behalf in full from the tort recovery regardless of whether the amount is greater than the portion of the recovery allocated to medical expenses. *Id.* The Court, however, found this interpretation to be

misguided, because ADHS ignored the remainder of §1396a(a)(25)(H), which clearly stated that the State must be assigned "the rights of [the recipient] to payment by any other party for such health care items or services." *Id.* The court stated that, "the statute does not sanction an assignment of rights to payment for anything other than medical expenses- not lost wages, pain and suffering nor inheritance." *Id.* ADHS also argued that §1396k(b) requires that the State be paid in full from a tort recovery/settlement before a recipient receives any amount. *Id.* §1396k(b) requires that "where the State actively pursues recovery from the third-party, Medicaid must be reimbursed fully from 'any amount collected by the state under assignment' before 'the remainder of such amount collected' is remitted to the recipient." *Id.* (quoting §1396k(b)). The Supreme Court, found that the amount "collected by the state under assignment" does not refer to the entire amount, but only to that portion designated to be for medical payments, and §1396 requires "that the State be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care," and not that the State be paid in full for its expenses before the recipient receives any recovery. *Id.* at 1761-1762.

The court also discussed the anti-lien statute, §1396, in response to ADHS's argument that it was inapplicable and stated that: "[t]here is no question that the State can require an assignment of the right or chose in action to receive payments for medical care. So much is expressly provided for by §§1396(a)(25) and 1396k(a). ... [T]he state can also demand as a condition of Medicaid eligibility that the recipient 'assign' in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§1396a(a)(25) and

1396k(a), it is an exception to the anti-lien provision. But that does not mean that the State can force an assignment of, or place a lien on any other portion of [recipient's] property....[T]he exception carved out by §§1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies." *Id.* at 1763. ADHS tried to argue that the anti-lien provision did not apply to the rest of the settlement, because the proceeds never became the recipient's property since there was an automatic assignment of the proceeds to the ADHS. *Id.* This argument was also made in the Georgia case of *Richards*. The US Supreme Court found that this argument failed. *Id.* The Arkansas statute clearly stated, "the assignment shall be considered a statutory lien on any settlement...received by the recipient from a third-party." Ark. Code Ann. §20-77-307(c). *Id.* at 1764. Thus, the Court found that based on the statute, settlement is not received until the proceeds are in the recipient's possession. *Id.* Therefore, the proceeds did not belong to the state until the recipient came into possession of the proceeds, thus, the proceeds did become the recipient's property. *Id.* The court noted that if the proceeds did belong to the state, then the state would not have had a need for a lien, because, "[a] lien is typically imposed on the property of another for payment of a debt owed by that other." *Id.* In its closing opinion, the Supreme Court held that, "[f]ederal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding \$35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so. Arkansas' third-party liability provisions are unenforceable insofar as they compel a different conclusion." *Id.* at 1767. As is demonstrated in the discussion of the two cases above, the Georgia Supreme Court's interpretation of the Medicaid lien statute is in conflict with the U.S. Supreme Court's

holding in *Ahlborn*, which occurred almost two years after *Richards* was decided. There have been no Georgia cases that have interpreted *Ahlborn*. One difference between the two courts' interpretations is that in the Georgia Supreme Court case, *Richards*, the Court holds that the GDCH can recover the full amount spent on the recipient's medical expenses whether that amount exceeds what has been allocated as the medical portion of the tort recovery and the court in *Ahlborn*, holds the opposite. *Richards* found that the Medicaid statute intended to vest states with the right to full recovery. *Ahlborn* found, however, that the Medicaid statute just intended the states to be able to recover its costs up to the amount designated in the tort settlement/recovery as medical expenses/costs. *Richards* found that O.C.G.A. §49-4-149, did not violate the Anti-lien provision, because the minute a recipient receives medical care funded by Medicaid, the statutory assignment occurs and the recipient assigns his proceeds to the state before he even receives them. *Ahlborn*, however, found that the Anti-lien provision applies to the other portions of the tort recovery/settlement besides the medical expenses portion and automatic assignment did not mean the proceeds did not become the recipient's property. Therefore, Georgia Supreme Court's holding in *Richards* of full reimbursement was rejected by the U.S Supreme Court's holding in *Ahlborn*.

### Conclusion

The United Supreme Court's holding in *Ahlborn* directly conflicts with *Richards*' holding and it affirms the view that the State may only recover up to the amount of the recipient's tort recovery deemed to be for medical care. *Ahlborn* addressed the issue of whether a recoupment by the state will be limited to those proceeds deemed to be medical expenses or whether

the state will be allowed to be fully reimbursed regardless of the proceeds designation. See *Lugo v. Beth Israel Medical Center*, 819 N.Y.S.2d 892 (2006). *Ahlborn* concluded that the Arkansas statute, which is similar to the Georgia statute, violated the Federal anti-lien provision by allowing the state to assert a lien on the recipient's personal property. See *id.* *Ahlborn* held that the Medicaid statute only permits the State to recover that portion of the settlement deemed to be allocated for medical expenses and any state statute that provides for a greater recovery is in conflict with the anti-lien statute. See *In Re Zyprexa Products Liability Litigation*, 451 F.Supp.2d 458 (2006)8. We believe the Georgia courts are bound the Supreme Court's decision in *Ahlborn*.

1 "A recipient of medical assistance who receives medical care for which the department may be obligated to pay shall be deemed to have made assignment to the department of any rights of such person to any payments for such medical care from a third-party, up to the amount of medical assistance actually paid by the department...." O.C.G.A. §49-4-149(d).

2 This case was reversed by *Ahlborn v. Arkansas Dept. of Human Svces*, 397 F.3d 620, (2005). Certiorari was granted in *Arkansas Dept. of Human Services v. Ahlborn*, 126 S.Ct. (2005); *Ahlborn v. Arkansas Dept. of Human Svcs*, 397 F.3d 620 (2005); affirmed by *Arkansas Dept. of Health and Human Svcs v. Ahlborn*, 126 S.Ct. 1752 (2006).

3 U.S.C.A. §1396p(a)(1) states, "No lien may be imposed against property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf..."

4 O.C.G.A. §9-4-149(d) states, "A recipient of medical assistance who receives medical care for which the department may be obligated to pay shall be deemed to have made

assignment to the department of any rights of such person to any payments for such medical care from a third party, up to the amount of medical assistance actually paid by the department...."

5 §1396a(a)(25)(B) has a requirement that States "seek reimbursement for [medical] assistance to the extent of such legal liability." *Id.* at 1761.

6 §1396a(a)(25)(H) states "that the State must have in effect laws that 'to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual' give the State the right to recover from third-parties. *Id.* at 1761.

7 1396(a)(18) requires that a State Medicaid plan comply with §1396p which prohibits States from placing liens against or seeking recovery of benefits paid from, a Medicaid recipient: (a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan. (1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan except- (A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual (b) Adjustment of recovery of medical assistance correctly paid under a State plan. (1) NO adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except [in circumstances not relevant here]. §1396p. 8 "In May 2006, the Supreme Court, in an unanimous decision, rejected the full-reimbursement approach in the Medicaid program, holding that the Federal Medicaid statute only permits a state to recover its Medicaid expenditures from the portion of a settlement attributable to medical costs." *In re Zyprexa*, 451 F.Supp. 2d at 470.

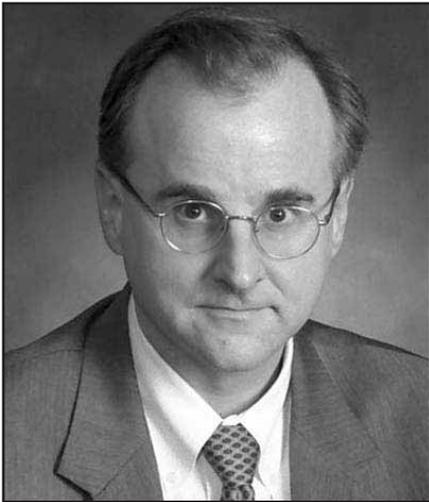
# Jury Instructions on Trials

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Exactly how bad are jury instructions in Georgia? Are they “grand conglomerations of garbled verbiage and verbal garbage.”<sup>1</sup> A subcommittee of the Bench and Bar Committee has been formed to find out and, if so, to make recommendations for changes. In the near future, mock juries will be used to give feedback on existing charges and a proposal for their reform.

## **I. Stating the Problem.**

Despite constant revisions over the years, Georgia jury instruction practice still suffers from some significant flaws, not least an important systemic malfunction. Under current practice, jury instructions are intended to state legally correct propositions of law that will shield the result from appellate review, rather than to assist juries in performing their true func-

tion. They often fail to focus jurors on the decisive fact issues that they must resolve and give them those rules, and only those rules, that they need to resolve those issues.

Because we are acculturated to the existing model, we often fail to see this shortcoming. Imagine instead that we are seated in a class to learn how to perform an appendectomy on a patient.<sup>2</sup> The lecture lasts about thirty minutes. The lecturer begins with an eight minute introduction on the name of the patient and the body parts; the scientific method; how to determine when a theory becomes more statistically probable than not – a point that seems very important because the lecturer repeats it in various ways five times; the importance of the surgeons and researchers who have dealt with appendectomies, but our responsibility to make our own

decisions about the value of their experience and research; the distinction between facts and opinions; the significance of gaps in the research; and the various ways in which surgeons and researchers might be reliable and right or unreliable and wrong.

Then the lecturer turns to reading sections of published articles on appendectomies, one article after another. These readings contain generalized observations about appendectomies, and they appear somewhat disjointed. Some observations are so general or obscure that it is unclear whether they even apply to the patient. The articles use quite a few words that are peculiar to the medical profession, without translating them into more familiar terms.<sup>3</sup> By reading from one article and then another, it is unclear whether the au-

thors were using their words in the same way or differently, and thus it is unclear whether they should be understood as saying the same thing or different things or even conflicting things. The lecturer refuses to explain how the articles apply to the patient. After several minutes of mental exertion attempting to understand the oration, we tire and our minds wander. We do not catch each word, each subtle distinction, each nuance.

The lecture ends, and we have been given no “big picture” of how all of the parts of the lecture fit together. The lecturer gives us no opportunity to ask questions, and the atmosphere of the lecture hall does not encourage us to ask them. When we gather up the courage to pose a question, the lecturer either refuses to answer the question or threatens to read the entire lecture again to avoid emphasizing any part of it. We are not permitted to take notes on the lecture, and the printed lecture is not allowed in the operating room.

This story, or much of it, tells the jury’s position under typical jury instruction practice in Georgia.<sup>4</sup> In one regard, though, jury instructions are far worse. Our adversarial system compounds the problems of such lectures through the method of submissions of reams of slanted proposed jury instructions, by which the parties essentially ask the judge to emphasize their favored points in their favored language and, all-too-often, to supply argument for the parties. A judge confronted with such instructions has a difficult job maintaining balance and comprehensibility, giving all correct instructions without appearing to favor one side or the other, all while keeping an eye on the state of the record for purposes of appellate review.

In the face of such problems, a number of courts have enacted a variety of reform measures. Some of these would be best characterized as “plain English” reforms, which are good as

far as they go for helping jurors understand. Others have gone further and focused their reforms on helping the jury perform its function, which is essentially fact-finding and fact-evaluation. This system is perhaps best developed in Kentucky, where it has been in place for decades,<sup>5</sup> but Massachusetts<sup>6</sup> has also recently gone this route, following the recommendation of the National Center for State Courts.<sup>7</sup> Nothing in this approach should be considered novel or foreign to Georgia, however. The truth is that it is the earliest approach to jury instructions. The first Chief Justice of Georgia, Joseph Lumpkin, described it as his approach in 1855.

I give it as the result of thirty-four years’ experience, that ordinarily, general charges, however abstractly true, are worse than useless -- their effect being to misguide, instead of directing the Jury to a right finding; and the only instructions which are worth any thing, are such as enable the Jury to apply the law to the precise case made by the proof. If the case comes within an exception or limitation of a general rule, restrict the investigation until the exact point upon which it turns stands out prominently before the eye of the Jury, stripped of all generalities. Their task is then comparatively easy and safe.<sup>8</sup>

These reforms recognize that the goal of jury instructions is not to qualify jurors to decide questions of law or interpret legal precedents. They are not expected to harmonize excerpts from case law and pass a bar examination on the subject. Jurors will not be able to reproduce a map of the contours of the applicable law simply because those contours cannot be learned by ordinary citizens through cramming. What is sensible to judges and lawyers, who have had years to learn the contours of the law, will remain opaque to jurors without similar training and experience.

Under this reform, jury instructions instruct jurors on their duty. They call for the jury to do some-

thing, rather than to contribute to the juror’s random knowledge of law. Instructions are framed around the parties’ respective burdens of proof and their contentions. Typically, a complete instruction on liability in a simple tort case would take the form, “D had a duty to do x, y, and z; if you believe from the evidence that D failed to comply with any of these duties and that the failure to comply was a substantial factor in causing P’s injuries, you should find for P; otherwise, you should find for D.”

## II. What Would Be Different?

The reader may ask what charges under this system might look like. Here are some examples, starting with the actual charge as given, followed by a proposed revision that does not change the legal content of the charge. Comments are appended to both sets of instructions to show what is problematic with our current system, and how it would look under a fact-issue centered reform.

### A. A Contract Case.

In this contract case, the parties disputed (a) whether a contract was formed in the first instance, and if so, (b) whether it was properly rescinded. [City], the defendant, made an offer to [Company], the plaintiff, and [Company] delivered the price of a foreclosure sale to [City]. [Company] claimed that this act accepted [City]’s offer. [City] claimed that this delivery was not consideration for [City]’s promise and that [City]’s offer was withdrawn before the delivery. [City] also claimed that both parties rescinded the contract. As for damages, [Company] claims a certain profit from the transaction with [City] and that it may have lost profits from other transactions which the Court has determined to be too remote, but which are otherwise in evidence. There is also an issue of mitigation of damages.

A few statistical observations are in order. In the instructions that were actually given, instructions

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on the merits of the case, i.e., liability and damages, occupy just 26% of the total instructions. Using WordPerfect's Grammatik program, this revised instruction reduces the total number of "words" from 2,111 to 62 (3%), the number of "big words" from 367 to 9 (2.5%), the words per sentence from 22.69 to 20.66 (91%), the grade level of comprehension from 12.6 to 11.4 (91%), passive voice from 17 to 11 on a 100 point scale (65%), sentence complexity from 75 to 52 on a 100 point scale (69%), and vocabulary complexity from 35 to 7 on a 100 point scale (20%).

### 1. Actual Instructions

Introduction. Ladies and gentlemen of the jury, you are trying the civil case of [Company] as plaintiff versus the [City] as defendant, case number \_\_\_\_\_ pending in [this] Court. Plaintiff has asserted a claim for damages against defendant, which defendant has denied.<sup>9</sup>

Rules of Evidence. Plaintiff has the burden of proof on its claim against defendant, which means the plaintiff must prove whatever it takes to make out its case, except for admissions by the defendant.<sup>10 11</sup> Plaintiff must prove its case by a preponderance of the evidence. Preponderance means superior weight of evidence upon the issues involved. That weight of evidence, even though superior, need not be enough to completely free the mind from reasonable doubt. But to be a preponderance, the weight of the evidence must incline a reasonable and impartial mind to one side of the issue, rather than to the other. If you find that the evidence is evenly balanced on any issue in the case, or if there is any doubt as to where the preponderance of the evidence lies, it would be your duty to resolve that issue against the party having the burden of proving that issue.<sup>12</sup> If you find that the weight of the evidence inclines your mind to one side of an issue rather than to the other, although some doubt may remain,

then you may still find that burden of proving that issue has been satisfied by a preponderance of the evidence because it is not necessary to remove all doubt.

You must determine the credibility or believability of the witnesses.<sup>13</sup> It is for you to determine what witness or witnesses you will believe and which witness or witnesses you will not believe, if there are some you do not believe.

In determining where the preponderance of the evidence lies and in passing upon the credibility of witnesses, you may consider all the facts and circumstances of the case, the witnesses' manner of testifying, their intelligence, their interest or lack of interest, their means and opportunity for knowing the facts which they testify about, the nature of the facts which they testify about,<sup>14</sup> the probability or improbability of their testimony, and of [sic] the occurrences which they testify about. You may also consider their personal credibility insofar as it may legitimately appear from the trial of this case.

You may believe or disbelieve all or any part of the testimony of any witness, expert or otherwise. It is your duty as jurors to determine what testimony is worthy of belief and what testimony is not worthy of belief.

You may also consider the number of witnesses,<sup>15</sup> but the preponderance of evidence is not necessarily in accordance with the greater number of witnesses.

Testimony has been given in this case by certain witnesses who are termed experts.<sup>16</sup> Expert witnesses are those who because of their training and experience possess knowledge in a particular field that is not common knowledge or known to the average citizen. The law permits expert witnesses to give their opinions based upon their training and experience. You are not required to accept the testimony of any witnesses, expert or otherwise. Testimony of an expert, like that of all witnesses, is to

be given only such weight and credit as you think it is properly entitled to receive.

To impeach a witness is to prove the witness is unworthy of belief.<sup>17</sup> A witness may be impeached by:

- a. Disproving the facts to which the witness testified; or
- b. Proof of contradictory statements, previously made by the witness, as to matters relevant to the witness's testimony and to the case; [sic]

If it is sought to impeach a witness by "b," above, proof of the general good character of the witness may be shown. The effect of the evidence is to be determined by the jury.

If any attempt has been made in this case to impeach any witness by proof of contradictory statements previously made, you must determine from the evidence:

- a. First, whether any such statements were made;
- b. Second, whether they were contradictory to any statements the witness made on the witness stand; and
- c. Third, whether it was material to the witness's testimony and to the case.

If you find that a witness has been successfully impeached by proof of previous, contradictory statements, you may disregard that testimony, unless it is corroborated by other creditable testimony, and the credit to be given to the balance of the testimony of the witness would be for you to determine.

It is for you to determine whether or not a witness has been impeached and to determine the credibility of such witness and the weight the witness's testimony shall receive in the consideration of the case.

Should you find that any witness, prior to the witness's testimony in this case from the witness stand, has made any statement inconsistent with that witness's testimony from the stand in this case, and that such prior inconsistent statement is material to the case and the witness's

testimony, then you are authorized to consider that prior statement not only for purposes of impeachment, but also as substantive evidence in the case.<sup>18</sup>

When you consider the evidence in this case, if you find a conflict in the evidence, you should settle this conflict, if you can, without believing that any witness made a false statement. If you cannot do this, then you should believe that witness or those witnesses you think best entitled to belief.<sup>19</sup>

An admission is a statement by a party or its agent that tends to aid the opposing party. All admissions shall be carefully considered.<sup>20</sup> When the circumstances require an answer or denial, or other conduct, acquiescence or silence may amount to an admission.<sup>21</sup>

Members of the jury, it is my duty and responsibility to ascertain the law applicable to this case and to instruct you on that law, by which you are bound. It is your responsibility to ascertain the facts of the case from all the evidence presented. It then becomes your duty and responsibility to apply the law I give you in the charge to the facts as you find them to be.<sup>22</sup>

Evidence is the means by which any fact which is put in issue is established or disproved. Evidence includes all the testimony of the witnesses from the witness stand, and the exhibits admitted during the trial. It does not include the opening statements and closing arguments. Nothing I say in the case is evidence.<sup>23</sup>

Evidence may be either direct or circumstantial or both.<sup>24</sup>

Direct evidence is evidence which points immediately to the question at issue.

Evidence may also be used to prove a fact by inference. This is referred to as circumstantial evidence. Circumstantial evidence is the proof of facts or circumstances, by direct evidence, from which you may infer other related or connected facts which are

reasonable and justified in the light of your experience.

The comparative weight of circumstantial evidence and direct evidence, on any given issue, is a question of fact for the jury to decide.<sup>25</sup>

Liability. A contract is an agreement between two or more parties for the doing or not doing of some specified thing. To constitute a lawful contract, there must be parties able to contract, a consideration for the contract, the agreement of the parties to the terms of the contract, and a lawful subject matter.<sup>26</sup> A consideration is valid if any person who promised is entitled to a benefit or any harm is done to one who receives the promise. The consent of the parties is essential to the validity or enforcement of a contract, and until both parties have agreed to all its terms, there is no contract. Until the contract is agreed to, a party may withdraw its offer or bid or proposition.

After a contract is made, neither party to such contract can rescind it merely by giving notice to the other party of the intention to do so without the agreement or consent of the other, but it may be rescinded with the consent of both parties. When a contract is rescinded, the parties shall be restored to their original status. It will be a jury question whether there was a contract between the parties created by the foreclosure sale and delivery of the sales price proceeds. If you so find, it will be a jury question as to whether there was a rescission of any such contract. If you find there was a rescission, you must find in favor of the [City].<sup>27</sup>

I charge you that the trial of this case is a legal investigation, and, being such, it is your duty in your deliberations to consider only the evidence presented to you at trial.<sup>28</sup> It is your duty to consider the facts objectively, without favor or affection or sympathy to any party.<sup>29</sup>

Damages. The fact that the Court is giving you legal instructions on the issue of damages is not to be consid-

ered by you that the Court has any opinion as to whether damages are or are not recoverable in this case. Should you consider the question of damages in this case, you are not permitted to go outside the evidence and guess or speculate as to what those damages may be. You should not consider the question of damages in this case until you have first determined whether or not defendant is liable for any of the damages claimed by plaintiff. If you find that the defendant is not liable to the plaintiff, then you would have no occasion to consider the question of damages.<sup>30</sup>

Damages are awarded as compensation for injury sustained. Damages recoverable for a breach of contract are such as arise naturally and according to the usual course of things from the breach and such as the parties contemplated when the contract was made as the probable result of the breach.<sup>31</sup> Remote or consequential damages are not allowed whenever they cannot be traced solely to the breach of the contract, unless they may be computed exactly, such as the profits that are the immediate fruit of the contract<sup>32</sup> and are independent of any collateral enterprises entered into in contemplation of the contract. When by breach of contract one is injured, one is bound to lessen or mitigate the damages as far as is practicable by the use of ordinary care.

Verdict/Deliberations.<sup>33</sup> If, after considering the testimony and evidence presented to you, together with the charge of the court, you should find and believe from a preponderance of the evidence that the plaintiff [Company] is entitled to recover, then the form of your verdict would be "we the jury find in favor of plaintiff in the amount of \$\_\_\_\_\_." If you do not think plaintiff is entitled to recover, you would find in favor of defendant [City]. I have prepared for you a verdict form.

Whatever your verdict is, it must be unanimous, that is, agreed by all twelve of you. The verdict must

*continued next page*

be signed by one of your members as foreperson, dated, and returned to be published in open court. You will give the verdict to the deputy and I will read it aloud in open court.

One of your first duties in the jury room will be to select one of your number to act as foreperson, who will preside over your deliberations and who will sign the verdict to which all twelve of you freely and voluntarily agree.

You should start your deliberations with an open mind. Consult with one another and consider each other's views. Each of you must decide this case for yourself, but you should do so only after a discussion and consideration of the case with your fellow jurors.

Do not hesitate to change an opinion if convinced that it is wrong. However, you should never surrender an honest opinion in order to be congenial or to reach a verdict solely because of the opinions of the other jurors.

Conclusion. By no ruling or comment which the court has made during the progress of the trial has the court intended to express any opinion upon the facts of this case, upon the credibility of the witnesses, upon the evidence, or upon the outcome of the case.

You may now retire to the jury room, but do not begin your deliberations until you receive the evidence which has been admitted in the case. The alternate jurors will go to a separate room and will be on standby should a juror fall ill or for other legal reason not be able to continue.

I have prepared a typewritten copy of these legal instructions and will send a copy with you to the jury room. I caution you that if you refer back to same, you should consider the jury instructions as a whole. If you have any questions during deliberations, please reduce same to writing, as succinctly as possible, and give it to the bailiff. I will attempt to answer the question

for you, if I can. However, I remind you that I cannot answer any factual questions because you the jury are the trier of facts in this case.

#### **The Reformed Instruction**

1. You will find for [Company] if you are satisfied from the evidence as follows:

(a) That the delivery of the foreclosure sale price benefitted [City]<sup>34</sup>; AND<sup>35</sup>

(b) That the delivery of the foreclosure sale price to [City] occurred before [City] told [Company] that [City]'s offer was no longer valid.<sup>36</sup> Otherwise you will find for [City].

2. Even though you might otherwise find for [Company] under Instruction 1, you will nevertheless find for [City] if you are satisfied from the evidence as follows:

(a) Both [City] and [Company] agreed to cancel their deal<sup>37</sup>; AND

(b) [City] returned the money that [Company] had given to [City].<sup>38</sup>

3. If you find for [Company] you will determine from the evidence and award it a sum of money equal to the difference between (a) the value of [City]'s offer and (b) the expenses that [Company] would have incurred to take advantage of [City]'s offer.<sup>38 39 40</sup>

#### **B. Other Cases.**

For reasons of space, this article will forgo discussions of other instructions we reviewed and revised.

The subjects included a case in which plaintiff sought to set aside a deed for undue influence, a land line dispute involving adverse possession issues, an inverse condemnation case, a medical malpractice case, and a car wreck case. A similar approach was taken, and similar results obtained using WordPerfect's Grammatik for comparison.

#### **III. Jury charges on trial.**

The committee has created a couple of fact patterns for testing with mock jurors who have been summoned to

appear for a trial term, but who are not chosen to serve. Both are taken from actual trials, one an automobile wreck and the other a medical malpractice. A lawyer will present what amounts to an abbreviated opening statement for each side. The judge will then give to one panel of jurors a set of instructions that was taken from the charges that were actually given, and a revised set to another panel. Both panels will retire to a jury room, where their deliberations will be videotaped. After about 20 minutes, they will be returned to open court, where they will be given written questions about the instructions. Until that point, jurors will not be advised that the instructions themselves are on trial.

The videotaping should help us see how juries use both sets of instructions. The questionnaire will ask for answers to questions designed to show how well the instructions enabled the jury to fulfill its fact-finding and evaluation roles. They will be asked questions about what the plaintiff needed to prove to win, and true-false questions about who should prevail if certain facts were proven. Other questions will test their understanding of points of law. They will be asked whether they had an impression that the judge favored either side. They will be asked to rank agreement or disagreement on a 1 to 5 scale with these propositions:

I understood the instructions that were given to me.

I understood how to apply the instructions to the facts of the case.

All of the instructions were useful in deciding this case.

The instructions were too long.

The instructions were too short.

The instructions used too many unfamiliar words.

Some of the instructions were ambiguous.

I referred to the written text of the instructions several times in deciding about this case.

They will ultimately be shown the other set of instructions and asked

which set would be more helpful.

The committee hopes that this process will yield significant information about how our system functions.

When jurors do not understand the instructions, the rational administration of law under our jury system fails to attain its goals. This should

be of concern to everyone who believes in our decentralized system of dispute resolution.

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## FOOTNOTES

<sup>1</sup> State Hwy. Dept. v. Price, 123 Ga. App. 655, 657 (2), 182 S.E.2d 175, 177 (1971).

<sup>2</sup> This illustration modifies an example given in David U. Strawn & Raymond W. Buchanan, *Jury Confusion: A Threat to Justice*, 59 JUDICATURE 478, 482 (1976).

<sup>3</sup> Is there a finer example of obscure jargon than the “proximate cause” instruction that is given in nearly all tort cases?

Proximate cause is that which, in the natural and continuous sequence, unbroken by other causes, produces an event, and without which the event would not have occurred. Proximate cause is that which is nearest in the order of responsible causes, as distinguished from remote, that which stands last in causation, not necessarily in time or place, but in causal relation. It is sometimes called the dominant cause.

Judge Mikell has described this mind-numbing language as “an affront to communication.” Charles B. Mikell, *Jury Instructions and Proximate Cause: An Uncertain Trumpet in Georgia*, 60 Ga. St. B. Jnl. 60, 61 (Nov. 1990) (though “proximate cause” is a convenient shorthand among lawyers for complex legal issues about the limits of liability, jurors may regard it as hair-splitting or double talk, if they understand it at all). Justice Weltner stated that “The second and third sentences of the charge on proximate cause are devoid of content and may be erroneous in that they speak of ‘remote’ being a type of ‘causation.’ (In reality, ‘remote’ traditionally has been the legal conclusion that there shall be no recovery.)” *Atlanta Obstetrics & Gynecology Group, P.A. v. Coleman*, 260 Ga. 569, 571 n.3, 398 S.E.2d 16, 19 (1990) (Weltner, J., concurring). A paraphrase of the second sentence was held to be confusing in *T. J. Morris Co. v. Dykes*, 197 Ga. App. 392, 395-96 (4), 398 S.E.2d 403, 405 (1990).

<sup>4</sup> This is not to overlook many fine efforts of judges who have taken numerous steps to ameliorate these problems, including printed charges to be taken to the jury room.

<sup>5</sup> John S. Palmore & Ronald W. Eades, *KENTUCKY INSTRUCTIONS TO JURIES* (1989).

<sup>6</sup> Peter M. Lauriat, *JURY TRIAL INNOVATIONS IN MASSACHUSETTS*, 83-84 (2000).

<sup>7</sup> G. Thomas Munsterman, Paula L. Hannaford & G. Marc Whitehead, eds., *JURY TRIAL INNOVATIONS*, 163-64 (National Center for State Courts, 1997): “Jury instructions are not intended to provide a crash course on governing legal principles so that duly educated jurors can engage in the same decision-making process as a well-trained judge. Rather, jury instructions should present the factual issues to be decided and those legal rules the jury must use in deciding such issues. Most instructions can be clarified by eliminating any unnecessary ‘legal education.’”

<sup>8</sup> *Haynes v. State*, 17 Ga. 465, 485 (1855). Other Justices have expressed similar thoughts. *Southern Cotton Oil Co. v. Thomas*, 155 Ga. 99, 99 (1), 117 S.E. 456, 459 (1923) (Russell, C.J.) (“If possible, the instructions of a trial judge should fit the evidence as snugly as a skillful tailor could make a suit of clothes to fit the human body.”); *Ransone v. Christian*, 56 Ga. 351, 357-58 (10) (1876) (“To give generalities, abstract propositions of law, to the jury in charge, would be error; to refuse to give them, and yet read nine sections of the Code without explanation, seems to us equally erroneous. What the jury need is a clear explanation of the law of the case at bar, and its plain application to the facts. If they believe such and such facts to exist, then such is the law.”).

<sup>9</sup> Introduction. This instruction can only be explained by its ceremonial

function of introducing the following instructions. Presumably the jury was present during the trial. See my article, *A Better Orientation for Jury Instructions*, 54 Mercer L. Rev. 1 (2002) (“BOJI”), text accompanying n.180.

<sup>10</sup> Burden. This paragraph on the burden of proof is replaced by statement of fact issues in this form: “if you believe (are satisfied) from the evidence that . . . , then you will find for [the party with the burden of proof on that issue]; otherwise you will find for [the other party].” See BOJI, nn. 181-198, for arguments that instructing on these metaphors of “weight” and “inclining minds,” and on side-issues such as “reasonable doubt” is needless at best (they need to be deciding whether [Company] accepted [City]’s offer in a timely fashion, not how heavy the evidence is), and at worst runs the risk of altering the burden of proof by elaborating on it or becoming argumentative through over-emphasizing it.

<sup>11</sup> Shifting Burdens. Following my proposed method of re-writing instructions avoids the error, suggested here, that the burden rests entirely on the plaintiff. Instead, the burden of proof on the affirmative defense of rescission and (if really applicable) the principle of mitigation of damages rests on the defendant. This entire charge does not hint that any burden rests on the defendant. To be consistent and correct under the current approach to jury instructions, the court should tell the jury at this point the issues on which the plaintiff bears the burden and on the other issues on which the defendant bears the burden, and either hope that the jury remembers them later when hearing a general instruction, or repeat them later. My proposal is much simpler.

<sup>12</sup> “Equally balanced evidence.” As to this potentially reversible error, see BOJI at n.194. The proposed system leaves it to counsel to draw these argumentative inferences from the correct instruction on the fact issue. Thus, counsel representing the party who has no burden of proof is free to argue precisely the content of this instruction, and the other counsel could not object or argue otherwise. But the court gets out of the business of arguing the case for one of the parties under the fact-issue system and leaves such arguments for the proper person in our legal system to make them.

<sup>13</sup> Credibility. These four paragraphs are also, at best, meaningless: The jury is instructed to believe what it finds believable. See BOJI at nn. 199-206 for other problems with similar instructions.

<sup>14</sup> Arguing credibility. Counsel is free to argue the actual facts that make favorable witnesses more credible and opposing witnesses less credible. The court should not have to do the argument for counsel.

<sup>15</sup> Number of witnesses. For this potential reversible error, see BOJI nn. 204-205.

<sup>16</sup> Experts. For the pointlessness, at best, of instructions on experts, see BOJI nn. 207-213.

<sup>17</sup> Impeachment. For the pointlessness of the following instructions on impeachment, see BOJI nn. 235-244. In general, as indicated in the charge on credibility, there is no difference between an impeached and an unimpeached witness as far as the jury is concerned: the credibility of both is to be determined by the jury in light of all facts and circumstances.

<sup>18</sup> Prior Inconsistencies as Substantive Evidence. This is not addressed in BOJI, but it should go without saying that the jury may consider everything it hears and sees from the witness stand as substantive evidence unless a limiting instruction is given.

<sup>19</sup> Conflicts. On the pointlessness of instructing the jury to believe the

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- witnesses that are most believable, see BOJI nn. 214-219.
- <sup>20</sup> Admissions. See BOJI n. 234. This particular version risks overemphasizing, and commenting on the weight of, a particular item of evidence.
- <sup>21</sup> Admission by silence. BOJI does not address this, but without doing further research, it strikes me as highly argumentative.
- <sup>22</sup> Roles of Judge and Jury. Perhaps this belongs, if anywhere, with the ceremonial first paragraph.
- <sup>23</sup> What is/is not Evidence. This is better placed in a preliminary instruction.
- <sup>24</sup> Direct and Circumstantial Evidence. The instructions on this subject are also pointless, since as far as the jury is concerned, there is no real difference between direct and circumstantial evidence: they simply decide the comparable weight of each type of evidence.
- <sup>25</sup> Placement of Instructions on Evidence. In general, post-trial instructions on evidence seem misplaced. It would be better to give them, if they are meaningful at all, at the outset of the case so that the jury can use them to interpret the evidence at the time they receive it, rather than to reflect back (while the judge proceeds to other charges) on what it concerns. But as argued previously, most of these instructions don't really help the jury make any decision at all.
- <sup>26</sup> Definition of Contract. The proposed fact-issue system avoids definitions like these sentences. Instead, it searches for real fact issues, eliminating non-issues (surely [City] and [Company] have capacity to contract, for instance), and presents only the real fact issues to the jury.
- <sup>27</sup> Liability Instructions. The last two paragraphs, which are the first instructions in this set that are actually useful to a juror in fulfilling his/her role, are not too very far away from what a fact-issue system would require. Until this point, the jurors have basically been told, repeatedly, that they are to consider what they have seen and to decide how believable it is. A juror like my wife could well wonder whether everything before this point was actually important.
- <sup>28</sup> Only the evidence. This seems more suitable for a pre-evidentiary instruction.
- <sup>29</sup> No sympathy. Some cases hold it error to charge on this subject unless a party has made an improper attempt to inject sympathy into the case.
- <sup>30</sup> Damages instructions. The points in this paragraph would probably not be necessary if a fact-issue charge is given. It is absolutely clear from the proposed re-written instruction that no damages will be awarded if the fact issues are resolved for the defendant. It is only where the charge rambles, as our charges typically do, that the human mind can fail to understand (it "drifts") the simple instructions proposed here. It is only where abstract instructions on damages are given, rather than precise concrete ones, that there could be a possibility of a jury's awarding damages on some invalid basis.
- <sup>31</sup> Abstract Definition of Damages. Such a general and abstract charge would be given only in the rare case in which the contract is so unusual that no more definite measure of damages is available. Instead, the court would typically give more specific measures of damages such as "the face amount of the note," or "the fair market value of the insured property," or "the difference between the agreed amount and the expenses the plaintiff would still incur to perform the contract," etc.
- <sup>32</sup> "Remote or consequential" damages. Literally, this charge refers to the "profits that are the most immediate fruit of the contract" as "remote or consequential." This is probably not what the Court meant, but it is misleading. "Remote" damages are never awarded. "Consequential" damages are awarded sometimes, though this instruction does not specify when, and it suggests no difference between the two. The absence of such a specification leads me to think that the Court had ruled out other damages for which [Company] contended. The Court really should have decided what alleged items of recovery were viable and given specific instructions on when they could be recovered, along with the measure.
- <sup>33</sup> Verdict and Deliberations. Except for the first paragraph of this section, which could be handled at the same time as the Court gives the proposed re-written instructions below, the rest of the paragraphs of this charge can be given orally after the argument of counsel (in the Kentucky system) or at this point (if counsel argue before the charge). It does not need to be given in writing.
- <sup>34</sup> Consideration. I am not sure that there really was an issue of consideration in the case. Perhaps there was some question of a pre-existing duty or of the city's rightful ownership of the money in the first place. If there was no real issue of consideration, this clause would be removed.
- <sup>35</sup> Contract Formation. Based on the instructions actually given, it does not appear that there was any real issue as to any of the other elements of contract formation.
- <sup>36</sup> Revocation of Offer. This assumes some facts, but the instruction should be couched in concrete terms of the facts presented to the jury rather than abstractions.
- <sup>37</sup> Rescission. Again, this is a guess as to a good description of what was allegedly rescinded. The instruction should be stated concretely in any case.
- <sup>38</sup> Restoration. The issue is stated only in terms of restoring [Company] to its original condition, rather than both parties restoring each other to the original position, on the assumption that restoring [Company] was the only real issue. This instruction is phrased concretely in terms of returning specific money to [Company], rather than abstractly in terms of restoring an original position, based on a further assumption about what the real issue was.
- <sup>39</sup> Damages. Measure of Lost Benefit of Bargain. This phrasing is illustrative of a more concrete example of the measure of damages than what was given: damages that "arise naturally and according to the usual course of things from the breach and such as the parties contemplated when the contract was made as the probable result of the breach." Even so, this phrasing is still abstract. It should be more concrete, and I would have made it so, but the instructions I had to work with give no clue as to what benefit [Company] was legally authorized to claim from the contract, if proven. In other words, in spite of their length, they do not assist the jury in solving one of the central issues in the case.
- <sup>40</sup> Collateral Loss of Profits. Narrowing the measure of damages to something like this, instead of the abstract instruction that was given, makes it unnecessary to define other types of damages that cannot be recovered. If an instruction on this point is still necessary, something along these lines would be appropriate here: "In determining this value, you should ignore [identify specific 'collateral enterprises' that are in evidence]."
- <sup>41</sup> Mitigation. It is unclear why an instruction on mitigation of damages was given. I see no issue of any damage to [Company] in the actual instructions other than the loss of the benefit of the bargain. Mitigation would not apply to [Company]'s delivering the foreclosure sales price to [City], since that act either accepted [City]'s offer (on [Company]'s theory of the case) or was a belated (and thus ineffective) "acceptance" (on [City]'s theory). Since the loss of profits on collateral transactions was excluded in this instruction, those damages could not be subject of a mitigation instruction. An advantage of this system is that it eliminates non-issues from jury consideration, and mitigation may be one of them.
- If an instruction on mitigation were required by the evidence, an instruction along these lines is appropriate: "[First set out the measure of damages as to which mitigation is relevant], but if you are further satisfied from the evidence that [Company] failed to exercise ordinary care to limit its expenses within a reasonable time after learning that [City] would not [perform its deal], you should exclude from the amount of the award the sum of the damages that you believe from the evidence would have been avoided by the exercise of ordinary care."

# Workers' Compensation Update for General Practitioners

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## I. Introduction

This year has seen some important changes which significantly impact the handling of workers' compensation cases in Georgia. This paper will address those we are most likely to encounter.

Sections of this paper include the State Board of Workers' Compensation (especially the new "paperless" system and the website), statutory revisions, rule changes, proposed legislation and new case law.

## II. State Board of Workers' Compensation

We are blessed to have an efficient and energetic State Board of Workers' Compensation. Chairman Carolyn C. Hall and Director Viola S. Drew were both reappointed by Governor Perdue last year. Considering both were initially appointed by Governor Barnes, this speaks volumes about their performances. We are also fortunate to have Director Warren Massey serving his first four year term.

Judge William "Bill" Cain is the Director of the Hearing Division. Ten offices of the State Board are spread throughout the state with twenty-one ALJ's.

The Alternate Dispute Resolution (ADR) Section is under the direction of Judge David Imahara. This section currently has seven full time mediators and two Administrative Law Judges conducting mediations in Atlanta and seventeen other locations in Georgia. These mediators conducted approximately three

thousand (3,000) mediations during 2006, successfully resolving eight-five percent of their cases. Also, the ADR section handles motions, attorney/contract approvals, and other matters.

Craig Henderson was recently named the new Director of the Settlement Division, replacing Lisa Gholson who will now be heading up the ICMS transition for the Board.

### a. SETTLEMENT DIVISION UPDATE

Mr. Henderson, Settlement Division Director, sent out a memo on February 1, 2007, detailing a more rigorous return/disapproval policy for stipulation and agreements (stip). The memo can be found on the Board's website under "Divisions and Offices," then under "Settlements," then under "Tips on Stips." This policy went into effect on February 15, 2007, and requires that the staff no longer "hold" a "stip" more than 48 hours in an attempt to procure needed documentation before rejecting it. The goal is to substantially lessen the number of days it takes to approve a properly crafted stipulation. Keeping in mind the following information will help reach this goal:

- Include the Board ICS claim number on the first page of the stipulation.
- Limit the dates of accident on the front page of the stipulation to only those dates of accident for which a WC-1 or WC-14 has been filed.

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- Provide complete documentation regarding the resolution of any liens, including child support or attorney liens.
- Document the stipulation with the appropriate and current medical information, as well as the timely filed Board forms, such as a WC-1 and WC-4.
- Itemize all expenses and explain any extraordinary expenses in the itemization.
- Any administrative costs in excess of \$50.00 must be itemized.
- Do not put any indemnification language in a stipulation purporting to protect the employer/insurer from costs of litigation, Medicare liens, or any other liens.
- Be prepared to establish a guardianship if one is needed for a minor child or incapacitated adult.
- Do not attempt to take attorney fees based upon medical issues, and attorney fees in excess of 25% will not be approved.

The Settlement Division's section of the Board's website also offers checklists for liability/no-liability settlements and lump sum/advance payments. Also, there are examples of liability/no-liability settlements and the "Hartman"/Social Security language. Finally, there is a link to the "Best Practices" for stipulated settlements.

#### **b. ICMS UPDATE – PHASE II**

After approximately two years of meetings, flow charts, analysis, etc., the State Board of Workers' Compensation successfully implemented the new ICMS, electronic document management system, on October 1, 2005. This system is being implemented in 4 phases: (1) Claims Processing—document capture; (2) Trial Management; (3) Web filing & access to the Board file over the web by parties and attorneys in a claim; and (4) Insurer/TPA EDI filing.

On August 21, 2006, the Board successfully implemented Phase II of ICMS. Some of the functions of ICMS Phase II are:

- Electronic processing of mediation/hearing requests
- Automated case assignment to judges
- Electronic calendars for ADR, Hearing, and Appellate Division
- Automated scheduling of hearings/mediations
- Electronic generation of judicial orders/awards with electronic signature

Notices of Hearing/Mediation/Oral Argument and awards/orders are being sent out by email. All of these documents are sent in PDF format. If an email containing an order, award, notice, etc. fails, the Board will mail a copy of such order, award, notice, etc.

The automated system generates a claim number for each new claim (e.g. 2005-001522, 2006-001523). It is a 10-digit number with the first four digits identifying the year the claim is created at the Board (not the year of the injury). Always remember, only a Form WC-1 or Form WC-14 will actually create a new electronic file. This number is a unique identifier for the claim. The Board will no longer use social security numbers on notices or awards/orders. The SSN is no longer the Board's Claim Number. This "Board Claim Number" must appear on every form or document filed by the parties/attorneys. See Board Rule 60 (c).

If there are multiple dates of injury, each date of injury is considered as a separate and distinct claim, and each will have a unique ICMS Board claim number. Unless you are submitting a claim-initiating document (e.g. a Form WC-14, Notice of Claim), you must include this claim number, with the associated date of injury, on the front page of every claim document you submit, including briefs and other documents for which a Form

does not exist. If multiple dates of injury are involved when filing a Form WC-14 Request for Hearing, please list the other ICMS Board Claim Numbers in section B of the form. However, when requesting a hearing for each date of injury and associated ICMS Board Claim Number, file a Form WC-14 for each one.

If you have a claim file that was created prior to October 1, 2005, your claim is most likely living in two worlds (paper and electronic). If you are a party to a claim created prior to October 1, 2005, you may not receive email notifications when documents are filed in these claims because the parties or attorneys of record have not been added to the claim in ICMS.

The Board is building a data base for storing attorney information. It is imperative that each attorney who practices Workers' Compensation law in Georgia forwards the following information by email to [ICMSprep@SBWC.ga.gov](mailto:ICMSprep@SBWC.ga.gov).

- Attorney mailing address
- Primary Email address
- Alternate Email address
- Phone Number & Fax Number
- Georgia Bar Number

Attorney information is for each individual attorney, not a law firm or multiple attorneys. At this time, only the primary email address is being used. Secondary addresses will not be activated until Phase 3. If you need to change any of your contact information, do so on a WC-Change of Address Form. In Phase 3, you will be able to update your information online.

The Board forms have been revised specifically to work with the new system, and the current version can be found on the Board's website at [www.sbwc.georgia.gov](http://www.sbwc.georgia.gov). You must use the proper form to report the information. Do not alter the Board forms in any way. If sufficient space does not exist on a form, do not alter

the form, but attach a supporting document adding information. For example, if more parties exist than is possible to list on a Form WC-14, attach a piece of paper showing all the correct parties to a claim. Be sure to put the claim number in the upper left hand corner of the attachment.

If the information on a form is not completed sufficiently for processing, it will be returned. The WC-1 is the most critical. The form must identify the employer, the insurance carrier or self-insured entity, as well as the claims office handling the claim. Please note that the Board is rejecting Form WC-1s if sections B, C, or D are not filled out.

When filing anything with the Board where no Board form exists, clearly identify what you are filing and place the Board claim number on each page of your document. The claim number can be hand-written if necessary, in the top left corner. When filing briefs also identify with whom you are filing your brief and who you represent. When filing appeals identify yourself as appellant or appellee. If required to provide a copy of a document to an ALJ or the Board clearly mark the "copy" in order to avoid duplication when scanning documents into the system.

Delays can be avoided by keeping in mind the following:

- Do not use outdated forms. All forms were changed effective July 1, 2005 and again on July 1, 2006, and are available on the Board web page ([www.sbwc.georgia.gov](http://www.sbwc.georgia.gov)). The current version is required.
- If a Form is available for the document you are filing, always use the form, even when you are including attachments.
- Never alter a Board Form to change the data or information fields.
- If a Form is not available for the document you are filing, clearly identify and name the document on the first page: e.g., Claimant's Brief; Employer/Insurer Brief for

Trial and ADR Divisions; Appellant's Brief; Appellee's Brief for Appeals, etc. Additionally, make sure the first page includes the New Board Claim Number and other claim-identifying information and your Bar Number.

- Except for Stipulated Settlements, Board Rules require that only one copy of a document is to be filed. If a judge or other Board personnel request an additional copy of a document be sure to clearly mark the document as a COPY so that duplicates are not scanned into the electronic claim file.
- Do not omit critical information that is mandatory for processing. Be sure to complete all of the information on the form.
- When filing a WC-14 – please ensure the following:
  - o Make sure you correctly identify the Insurer or Self-insurer and the claims office (TPA). Please note that coverage information for insurers and self-insurers is now available for online lookup at [www.sbwc.georgia.gov](http://www.sbwc.georgia.gov)
  - o The county of injury, accurate first and last name of the claimant, social security number, and date of injury.
  - o If the WC-14 is not the claim-initiating document you should use the ICMS Board Claim Number, which eliminates many errors and creation of incorrect duplicate files.
  - o A separate WC-14 is needed for each date of injury to create a claim file. Each claim file will have a unique Board Claim Number.
  - o Identify the parties completely and fully. Most importantly, identify the employer as insured or self-insurer. For coverage verification and SBWC ID #'s, see the web page at [www.sbwc.georgia.gov](http://www.sbwc.georgia.gov). If the employer is insured, please identify the

insurer and the claims office.

- Use the correct form for the action you are requesting. See the SBWC website ([www.sbwc.georgia.gov](http://www.sbwc.georgia.gov)) for forms and Board Rules, in particular Board Rule 61(b). If you are filing an objection to a motion filed by WC-102d, use the WC-102d. If you are filing an objection to a WC-200b on treating physician or medical treatment, use the WC-200b.
- Include the Board Claim Number!
- In the current system the Board does not need written confirmation from the attorneys on resets, unless specifically instructed by the Judge's office.
- Claimant's attorney should file an attorney fee contract, and defense attorneys should file a notice of representation (Form WC-102b) for every claim.

Coming soon, the Board will implement Phase III wherein ICMS will permit Web-based submission of forms as well as file review over the Internet. Documents that supplement claim forms can be submitted as attachments over the Internet.

Once registered, you will be able to submit forms and to view electronic claim files for which you are a party or attorney of record. Remember that many active claim documents filed prior to October 1, 2005, will still be in paper format and therefore not viewable over the Internet. The Board will offer training on the new Internet-based capabilities later this year. Details on this training will be released in the coming months.

### III. 2006 STATUTORY CHANGES

A summary of the 2006 statutory changes effective July 1, 2006, is attached as Appendix A. The complete statutory changes are available at the Board's web site.

Importantly, O.C.G.A. §34-9-203 was amended to raise the maximum cap on death benefits from \$125,000.00

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to \$150,000.00, the first increase since July 1, 2000. O.C.G.A. § 34-9-203 was amended to clarify that an injured worker has one (1) year from the date he incurs mileage expenses to submit them for reimbursement. O.C.G.A. §34-9-362 is a new provision that allows the employer/insurer three (3) years from the date the SITF receives notice to obtain a reimbursement agreement issued by the SITF for claims filed after July 1, 2006. If no agreement is obtained from the SITF within this time the claim shall be deemed automatically denied.

#### IV. 2006 BOARD RULE CHANGES

A summary of the 2006 Board Rule changes is attached as Appendix B and can be found on the Board's website. The rule changes reflect the implementation of the ICMS and the new Board forms. Board Rule 61 was most affected by the recent changes.

The following changes are noted:

- **Rule 15** – amended (f) to require the filing of a Form WC-1 when filing a “no-liability” stip.
- **Rule 61** –
  - Amended **(b)(1)** – requiring insurer or self-insurer to include their SBWC ID # on WC-1 when filing (available on Board's website). Additionally, WC-1 may be rejected if not completed properly.
  - Amended **(b)(2)**- clarifying that Form WC-2 must be filed when paying benefits under O.C.G.A. §§ 34-9-261, 34-9-262 or 34-9-263.
  - Amended **(b)**- which amends Forms WC-14, WC-14a, WC-121, WC-200a, WC-240 and WC-240a.
  - At **(b)(26)** - renumbered to add 4 new forms: Permit to Write Insurance and corresponding Permit to Write Insurance Update at **(b)(26)** & **(b)(27)**, and the Rehabilitation Supplier application and corresponding renewal at **(b)(48)** & **(b)(49)**.
- Added New Sections: **(b)(54)**- requires all forms be filed on the most current version or risk rejection by the Board and, **(b)(55)**- permits service of a form with the ICMS equivalent.
- **Rule 100** – (f) rewritten concerning confidentiality for mediations; (g) rewritten regarding attendance at mediations; (h) rewritten regarding postponement procedures for mediations; and, new section (i), created to strongly discourage misconduct during mediations.
- **Rule 102** – New sections: (A)(2) was created to follow the Uniform Superior Court rule concerning Admission Pro Hac Vice; (A)(3) was created requiring attorneys to place Georgia Bar numbers on all filings and to use the most current Board forms; (E)(7) permitting Board to send Hearing Notices by email. Amended: (C)(1) to clarify procedures regarding postponement of hearings; (D)(1) limiting motions to 50 pages; (E)(3)(b) clarifying remedies available under the section; and (E)(4) limiting hearing briefs to 30 pages.
- **Rule 108** – amended requiring claimant's attorneys to include the following information on all attorney fee contracts: name, bar number, firm name, address, phone number, fax number, email address and Board claim number.
- **Rule 200** – (b)(1) amended to limit change of physician motions to 50 pages.
- **Rule 200.1** – amended: (e)(2)(iv) to allow objections to rehab plans to be filed within 20 days; (e)(3) clarifying attendance at rehab conferences; (f)(2)(i) no longer requires academic transcripts or professional licenses when registering as a rehab supplier; (f)(2)(iii) & (f)(4)(ii) struck “Director of Licensure & Quality Assurance” and replaced it with “Board.”
- **Rule 202** – amended for clarification.
- **Rule 203** – amended to raise mileage reimbursement rate to 40 cents/mile.
- **Rule 221** – rewritten for clarification.

#### V. PROPOSED LEGISLATION

House Bill 424 (copy attached as Appendix C) proposes a few important changes to the Workers' Compensation Act. This bill comes from the Board's Advisory Council which is composed of leaders from the insurance, labor, medical, legal, small business and business sectors. The bill contains the following proposed amendments:

- O.C.G.A. §34-9-100 amended would, by operation of law, dismiss with prejudice any claim filed after July 1, 2007, where neither medical nor income benefits have been paid, if no hearing is held within five (5) years from the date of accident. This will not apply to occupational disease cases.
- O.C.G.A. §34-9-200.1 amended would give the employer twenty (20) days instead of fifteen (15) to select a rehab supplier, or one “shall” be appointed by the Board.
- O.C.G.A. §34-9-202 amended would allow examination to include physical, psychiatric, and psychological independent medical examinations, requested by either employer/insurer or employee.
- O.C.G.A. §34-9-205 amended would allow for the fee scheduling of prescription drugs and other “items and services.”
- O.C.G.A. §34-9-261 amended would raise the maximum TTD from \$450.00 per week to \$500.00 per week, and the minimum TTD from \$45.00 to \$50.00 per week.
- O.C.G.A. §34-9-262 amended would raise the maximum TPD payment from \$300.00 per week to \$334.00 per week.

## VI. SUMMARY OF 2006 CASE LAW

### Change in Condition Without Previous Payment of Income Benefits

*Footstar, Inc. v. Stevens*, 275 Ga. App. 329, 620 S.E.2d 588 (2005), *cert. granted*, involved a dispute between two workers' compensation carriers over whether an employee had undergone a change in condition or suffered a fictional new accident. The Georgia Supreme Court affirmed the Georgia Court of Appeals, finding that an employee's condition was caused by a change in condition for the worse rather than a new accident, even though the employee had *not* yet received any income benefits.

In November 1999, the employee sustained work-related injuries to her head, neck and shoulder while putting merchandise into an overhead bin. The claim was accepted as a "medical only" claim by Traveler's Insurance Company, the insurance carrier at that time. Subsequently, in January 2001, Traveler's was replaced by Liberty Mutual Insurance Company as the workers' compensation carrier. Traveler's then requested a hearing to determine whether the subsequent carrier would be responsible for future medical treatment. The ALJ issued a December 2001 award finding that the employee had sustained a compensable work-related injury in November 1999, and that Traveler's would be responsible for the continued medical payments because it was the carrier at the time of injury. The employee did not request or receive income benefits during this time because she continued working.

The employee's condition gradually worsened until January 2002, at which point she was required to cease work. Traveler's, the initial carrier, denied responsibility for paying income benefits based upon the theory that the employee had sustained a fictional new accident on the date she was required to cease work. Liberty Mutual, the subse-

quent carrier, denied responsibility for the claim based upon the theory that the employee had sustained a change in condition for the worse from the original "medical only" claim. After a hearing on the issue, the Administrative Law Judge found that a fictional new injury had occurred on January 5, 2002, and held Liberty Mutual responsible for the new accident. The Board's Appellate Division reversed the ALJ and held that the employee's departure from work in January 2002 did *not* constitute a fictional new injury, but rather, a change in condition for the worse.

The Supreme Court affirmed the Court of Appeals decision which had affirmed the award issued by the Appellate Division. The Supreme Court narrowed the issue to "whether the workers' compensation 'change in condition' statute, O.C.G.A. § 34-9-104, is limited to cases where income benefits have been awarded from the outset." The Court rejected Traveler's contention that the change-in-condition statute does not apply unless the claimant has previously received income benefits. Instead, the Court concluded that the facts of this case bring it within the statutory definition of a change of condition in O.C.G.A. § 34-9-104 (a)(1) because the employee's condition, or status, had been established by the ALJ's 2001 "medical only" award, denying Traveler's contention of a new injury. The Court used the principles of statutory construction set out in *Sikes v. State*, 268 Ga. 19(2) (1997), to decide that "[a] construction of O.C.G.A. § 34-9-104 that includes prior awards of medical benefits only within the change-in-condition provisions of subsection (a)(1), and restricts the period of limitation provision in subsection (b) only to prior claims of income benefits, permits the language of each section to be meaningful, brings the sections into harmony with each other, and accords with the intent of the legislature in enacting workers compensation laws."

The Court recognized that this statu-

tory construction would provide for a period of limitation only for change-in-condition cases involving prior awards of income benefits. Thus, there would be no limitation period for change-in-condition cases in which the previous award had authorized medical benefits only. The Court went on to say that this interpretation is fully consistent with the humanitarian purposes of the statute because it allows the employee that is injured and needs medical treatment, but is able to continue working, to do so with confidence that should the stresses of work cause a worsening of the condition requiring the employee to cease work, the employee would then be entitled to seek income benefits.

Thus, the Supreme Court agreed with the Court of Appeals and the Appellate Division that the initial insurance carrier, Traveler's, was responsible for providing the income and medical benefits because a change in condition for the worse, rather than a fictional new injury, had occurred after the employee's status had been established by award or otherwise. In this case, the ALJ's December 2001 ruling established the employee's status.

The ultimate reach of this case is unclear, because the facts were unusual. There is no question, however, that the State Board has departed from the established notion that there could be no change in condition without the previous payment of income benefits. It also warns employers/insurers to be cautious about litigating medical only issues, as Traveler's initially did, because it could open the door to future change in condition cases with no statute of limitations.

### Employee Was Fatally Injured While Returning From A Purely Personal Mission And The Accident Was Still Deemed Compensable

In *Ray Bell Constr. Co. v. King*, 277 Ga. App. 144, 625 S.E.2d 541 (2006),

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*cert. granted*, (June 12, 2006), Mr. King was employed as a construction superintendent on a project in Butts County. In order to keep him close to the site, the Employer provided him with housing in Fayetteville. In addition, Mr. King was provided a company-owned truck and was allowed to use it for work and personal reasons. One Sunday before he was set to return to work on Monday, Mr. King transported a load of family furniture to Alamo for storage. Unfortunately, as he was returning to his employer-provided housing, he was involved in a motor vehicle accident that proved fatal. Following same, a workers' compensation claim seeking dependent benefits was filed on behalf of Mr. King's minor child. The Employer argued that Mr. King was on a personal mission and, thus, had deviated from the scope of his employment so as to render the claim not compensable.

However, the ALJ found that Mr. King's employment relationship with the Employer was one of continuous employment. The test to be used in determining whether one is engaged in continuous employment is: if an employee, while working away from his home, is required by his employment to lodge and work within an area geographically limited by the necessity of being available for work on the employer's job site, is in effect in continuous employment. In addition, the evidence presented indicated that Mr. King was returning to either his company housing or to the job site. As such, the Board found that although Mr. King may have deviated from his employment by taking personal furniture to a neighboring county, the deviation had come to an end and he had recommenced his employment duties so as to make his death compensable. The appellate division affirmed as did the superior court. The Employer was granted discretionary review by the Court of Appeals.

The Court of Appeals noted that

employees considered to be in continuous employment had a broader scope of employment. In addition, the Court indicated that traveling employees are also subject to the continuous employment principle because they are subject to the perils of the highway and the hazards of hotels. The Court did point out that an employment relationship that is continuous does not in any way mean that an employee can not stray from his job so as to constitute a deviation. The Court pointed out that Mr. King's personal mission had ceased and he was returning to his housing at the time of death as found by the ALJ. However, the Court did indicate that the doctrine of turning around will not render an injury compensable solely by a claimant concluding his or her personal mission and turning around. The employee must return within a general geographic area. The determination of the boundaries of same requires a fact-intensive determination by the Board. Although the Board did not make a written finding with regard to his general geographic area, there was some evidence implicit in the record to support the Board's decision awarding compensation. Therefore, the Court of Appeals affirmed the decision.

Oral arguments were heard in this matter before the Supreme Court of Georgia on September 18, 2006, and the rumor is that the decision will be reversed.

#### **Two Year Statute of Repose on Benefit Reimbursement**

On February 2, 2006, the Court of Appeals decided *Trax-Fax, Inc. v. Hobba*, 277 Ga. App. 464, 627 S.E.2d 90 (2006), *cert. denied*, (May 8, 2006), a significant case on the issue of reimbursement. Mr. Hobba (hereafter Claimant), the sole shareholder of Trax-Fax (hereafter Employer), suffered a work-related injury on July 28, 1998. Travelers (hereafter Insurer) voluntarily commenced

benefits, issuing maximum temporary total disability (TTD) benefits to the Claimant. However, on April 24, 2002, the Insurer suspended benefits, although the WC-2 was not actually filed until December 10, 2003. The suspension was based on the belief that the Claimant had previously returned to work but fraudulently continued to receive TTD benefits. On December 10, 2003, the Insurer also requested a hearing seeking, among other things, reimbursement of income benefits paid, pursuant to O.C.G.A. § 34-9-104 (d)(2).

The Administrative Law Judge (ALJ) issued an award in favor of the Insurer, finding that the Claimant was never totally economically disabled. The ALJ ruled that the Insurer was entitled to full reimbursement of all TTD benefits paid to the Claimant, pursuant to O.C.G.A. § 34-9-104(d)(2). The ALJ held that the statute of limitation defense raised by the Claimant in his brief was waived because the Claimant did not raise it as a defense at the hearing. It should be noted that the Claimant cited O.C.G.A. § 34-9-104 and O.C.G.A. § 34-9-245 in support of his statute of limitation defense. O.C.G.A. § 34-9-104(d)(2) states that the ALJ may order the employee or beneficiary to repay to the employer or the insurer the sum of the overpayments. Similarly, O.C.G.A. § 34-9-245 states that no claim for reimbursement shall be allowed where the application for reimbursement is filed more than two years from the date such overpayment was made.

The Appellate Division affirmed the ALJ. The Claimant subsequently appealed to the Superior Court, which made an important interpretation with respect to O.C.G.A. § 34-9-245. Essentially, the Claimant argued that O.C.G.A. § 34-9-245 was a statute of repose rather than a statute of limitation. The Superior Court agreed and held that the Insurer was entitled to reimbursement of only those benefits paid in the two years prior

to the hearing request. Thus, because the Insurer requested the hearing on December 10, 2003, it could seek reimbursement of benefits paid only since December 10, 2001.

The Insurer appealed to the Court of Appeals, which agreed with the Superior Court's interpretation of O.C.G.A. § 34-9-245. The Court explained: A statute of limitation is a procedural rule limiting the time in which a party may bring an action for a right which has already accrued. A statute of ultimate repose delineates a time period in which a right may accrue. If the injury occurs outside that period, it is not actionable (Trax-Fax, 277 Ga. App. at 467). This interpretation is significant because, unlike a statute of limitation, a statute of repose cannot be waived.

Under the Trax-Fax opinion, a claim for reimbursement is actionable for only two years from the date of overpayment. Any payments made more than two years before the hearing request are not recoverable under O.C.G.A. § 34-9-245. Therefore, any claim for reimbursement should be made as soon as possible and within two years from the date of overpayment.

#### **Burden Placed Upon Claimant Seeking TPD Benefits**

In *Roberts v. The Jones Co.*, 277 Ga. App. 517, 627 S.E.2d 139 (2006), the Court of Appeals held that the Administrative Law Judge (ALJ) placed an inappropriate burden on Ms. Roberts when she was denied temporary partial disability income benefits. Ms. Roberts was an employee of The Jones Company, d/b/a Flash Foods, when she sustained a work-related injury to her wrist. When she returned to her job in a light duty capacity, Ms. Roberts was fired for reasons unrelated to her disability. In an effort to find another job, Ms. Roberts engaged in what was determined to be a diligent job search. Initially, however, she was unsuccessful in finding work. Even-

tually, she found a lower paying job as a waitress at Huddle House.

Thereafter, Ms. Roberts filed a claim against Flash Foods seeking temporary total disability (TTD) for the period of time that she was unemployed, and also temporary partial disability (TPD) based upon her lower paying job at the Huddle House. The ALJ awarded Ms. Roberts TTD benefits during her period of unemployment, but denied TPD based upon her failure to put forth any evidence that the lower earnings were related to the injury suffered while she worked for Flash Foods. The decision was upheld by the Appellate Division and was affirmed by the Superior Court. Ms. Roberts then appealed the denial of benefits to the Court of Appeals.

In deciding to reverse and remand the decision of the ALJ, the Court of Appeals looked to the decision of the Georgia Supreme Court in *Maloney v. Gordon County Farms*, 265 Ga. 825, 462 S.E.2d 606 (1995). In that decision, the Supreme Court held that workers' compensation benefits based upon a change in condition may be awarded if the claimant proves: (1) that he or she suffered a loss of earning power as a result of a compensable work-related injury; (2) that he or she continues to suffer physical limitations attributable to that injury; and (3) that he or she has made a diligent, but unsuccessful, effort to secure suitable employment following termination. Once this evidence has been presented, an ALJ may reasonably infer that the inability to obtain suitable employment was proximately caused by the continuing disability. The *Maloney* decision specifically rejected the requirement that a claimant show that he was denied employment because of a continuing work-related disability. The *Maloney* decision indicated this was an often impossible burden for a claimant to meet because it would require evidence of the motive and state of mind of the

employer.

In *Roberts*, the Court of Appeals held that the ALJ correctly applied the principle set forth in *Maloney* with respect to the award of TTD, but had incorrectly denied TPD on the grounds that the Claimant did not present evidence that the reduced earnings were related to her wrist injury. The Court ruled that the *Maloney* inference was not limited to cases involving total disability. The Court stated that when a claimant diligently searches for a job before ultimately taking one that pays less, the need for temporary partial disability benefits is no less compelling than the case for temporary total disability benefits under *Maloney*. To make a contrary decision would dissuade a motivated worker from seeking another job. Therefore, the Court reversed and remanded with directions that the ALJ reconsider the case under the correct standard.

#### **Court of Appeals Upholds Denial of Income Benefits to Illegal Alien**

In *Martines v. Worley & Sons Construction*, 278 Ga. App. 26, 628 S.E.2d 113 (2006), the Georgia Court of Appeals affirmed the Superior Court's reversal of the State Board's award of income benefits in a case involving an illegal alien. The Court of Appeals agreed with the Superior Court that a light duty driving position offered pursuant to O.C.G.A. § 34-9-240 was suitable, and that the employee's refusal of that job due to his inability to obtain a valid driver's license because of his undocumented worker status, was not justified.

The facts of the case were not in dispute. Mr. Martines suffered a compensable injury to his left foot. After medical treatment, he was released by his physician to return to work with restrictions. *Worley & Sons* offered him a light duty job as a delivery truck driver, a position clearly within the restrictions set by his physician. When he reported to work, Mr. Martines was unable to

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produce a Georgia driver's license, and he could not obtain one because he had entered the United States illegally. The employer subsequently suspended income benefits due to the employee's unjustified refusal of the light duty position.

At the hearing before the Administrative Law Judge (ALJ), Mr. Martines did not present any evidence that he was unable to drive for any health-related reason. Also, he acknowledged that he drove in Mexico and he did not deny that he would drive if he could obtain a license. In addition to finding that Mr. Martines did not undergo a physical change for the better as of the date he was offered work, the ALJ also found that the job offered was not suitable because the employee did not possess the driver's license required for the job. The State Board's Appellate Division affirmed the judgment of the ALJ.

The Superior Court reversed the State Board, finding that the Board had applied the wrong legal standard to determine the suitability of the proffered job. The Superior Court concluded that Mr. Martines had not met his burden of demonstrating that his refusal of the work was justified, and accordingly, it reversed the award of temporary total disability benefits.

The Court of Appeals affirmed, addressing whether the employee's refusal of the delivery truck driver position was justified. For a refusal to be justified, it must be related to the physical capacity of the employee to perform the job, the employee's ability or skill to perform the job, or factors such as geographic relocation or travel conditions that would disrupt the employee's life. The Court noted that an employee is justified in refusing work that aggravates his injury, work that requires relocation, or work that he lacks the skills to perform, such as typing.

The Court explained that there was no question that Mr. Martines could drive a car, but that he was unable

to acquire a Georgia driver's license because of his illegal status. The Court determined that Mr. Martines's legal status was analogous to that of an individual whose driver's license has been suspended or revoked for a violation of the law, or of a person incarcerated after an adjudication of guilt.

Illegal status alone does not bar an employee from receiving workers' compensation benefits. In this case, however, Mr. Martines's inability to perform the suitable job stemmed from his legal inability to acquire the necessary driver's license; therefore, his refusal to accept the proposed light duty work was not justified as a matter of law.

#### **Claimant Follows Order But Does Not Read Between The Lines**

On May 12, 2006, the Court of Appeals decided *Dallas v. Flying J, Inc*, 279 Ga. App. 786; 632 S.E.2d 389 (2006). The facts giving rise to this appeal follow. The claimant was awarded TTD benefits following a compensable on-the-job injury in December of 2000. In that regard, on August 12, 2003, the ALJ issued an order that the Claimant was to call his treating physician and schedule an appointment within fifteen days, attend the appointment and cooperate with the treatment. However, the Claimant never returned to the treating physician, and his benefits were suspended in December of 2003 for failure to cooperate with medical treatment, pursuant to O.C.G.A. § 34-9-200. Following the suspension of benefits, the claimant requested a hearing to have his benefits reinstated and increased due to an incorrect AWW and assessed attorney fees. The record shows that the clinic where the ATP worked was a walk-in clinic and did not issue appointments. Rather, the claimant was told numerous times when he called to schedule an appointment to just come in and he could be seen on a first come- first served basis. There-

fore, the claimant contended that he complied with the letter of the ALJ's order in that he called to schedule the appointment, but that the ATP would not give him an appointment. For this reason, the ALJ reinstated the benefits effective September 1, 2003. As to the AWW wage issue, the ALJ considered the evidence and raised the AWW from \$486.65 to \$550. The ALJ did not address the issue of assessed attorney fees.

On appeal to the Appellate Division, the ALJ's award was reversed. Essentially, the Appellate Division found that the Claimant failed to cooperate with medical treatment by not returning to the [ATP], and it suspended his benefits pending his return for treatment. Moreover, the Appellate Division affirmed the increase in AWW but found no basis for assessing attorney fees, an issue raised by the Claimant on cross appeal. The Claimant appealed to Superior Court, which failed to rule within twenty days, thereby affirming the decision by operation of law under O.C.G.A. § 34-9-105(b).

The Court of Appeals granted Claimant's application for discretionary appeal and, ultimately, affirmed. In *Dallas*, the Court of Appeals reminds us that it and the Superior Court is bound by the any evidence rule and cannot substitute itself as a fact finding body in lieu of the board( *Dallas* at 3). In reviewing the primary issue regarding the reinstatement of benefits, the Court found evidence to support the Appellate Division's decision. Specifically, the record reflects that Claimant was informed by the ATP on several occasions that the clinic did not take appointments, but that he could receive treatment on a first come- first served basis( *Dallas* at 10). The Appellate Division rejected Claimant's argument that it was unreasonable to expect him to wait in a room with other sick patients for an opportunity to be seen. The Court of Appeals, therefore, found

evidence that Claimant knew he could be seen by a doctor by walking into the clinic. As to the wage issue, the Court of Appeals determined that because Claimant did not challenge the \$550 calculation before the Appellate Division, he could not now question the finding. Because the Appellate Division's findings were affirmed, the Court determined that an award assessing attorney fees was not appropriate, as requested by Claimant.

### **An Alligator Farm Is Not Really a "Farm"**

On June 8, 2006, the Court of Appeals was presented with a rather novel issue in *Gill v. Prehistoric Ponds, Inc.*, 2006 Ga. App. LEXIS 671, 2006 Fulton County D. Rep. 1788 (2006). In *Gill*, the Employer was in the business of raising and slaughtering of alligators and would sell the hides, meats, and other parts. However, the majority of the Employer's revenue came from the hides. The Claimant's job was to clean out the alligator pens. On one unfortunate day, the Claimant was cleaning out a pen and was bitten on the thumb by an alligator. The Claimant developed various infections and ended up being hospitalized for four days and was out of work for a week. The Employer paid the Claimant his salary in lieu of compensation but denied payment of certain medical expenses.

Thereafter, the Claimant filed a claim for workers' compensation benefits. The ALJ likened the Employer's business to the raising, feeding, and care of livestock. In addition, the ALJ determined that the Claimant was a farm laborer pursuant O.C.G.A. § 34-9-2(a) and, as such, was not entitled to workers' compensation benefits. The appellate division reversed the ALJ, finding that alligators are not livestock but are instead game animals under O.C.G.A. § 27-1-2. In addition, the appellate division pointed out that livestock businesses

are regulated by the Department of Agriculture, whereas alligator farms are regulated by the Department of Natural Resources. Moreover, in support of its position, the appellate division indicated that farming is defined in *Pridgen v. Murphy*, 44 Ga. App. 147, 160 S.E. 701 (1931), as the cultivation of land for the production of agricultural crops, with incidental enterprises.

Despite the extensive reasons cited by the Appellate Division, the Superior Court reversed the award, finding that the Appellate Division's determination that the alligator farm was non-agricultural was error, and that testimony that the Employer also raised goats was not considered. Consequently, the Claimant applied for discretionary review and the Court of Appeals granted same.

The Court of Appeals held that the Superior Court exceeded its authority by ruling that the Appellate Division should have considered the testimony with regard to the raising of goats. The Court noted the longstanding rule that a superior court is not authorized to substitute itself for the Board as a fact-finding body. Next, the Court considered the most pressing issue at hand - whether or not an alligator farm employee is a farm laborer under O.C.G.A. § 34-9-2. In order to determine this issue of first impression, the Court was forced to consider other areas of Georgia law. Specifically, the Court considered the definitions contained in the *Employment Security Law* (ESL) found in O.C.G.A. § 34-8-35. Under the ESL, agricultural labor includes the raising or harvesting of any agricultural or horticultural commodity including fur-bearing animals *and wildlife*. However, the definition of a farm under the ESL did not include the raising of wildlife. Therefore, according to well-known statutory interpretation principles, the Court concluded that although the Claimant was performing agricultural labor at the time of his injury, the alligator

farm was not a farm under the ESL and, as such, the Employer was not entitled to an exemption from the mandates of Georgia Workers' Compensation Act under O.C.G.A. § 34-9-2(a).

*Cook v. Prehistoric Ponds, Inc.*, No. A06A2127 Ga. App. (Dec. 14, 2006) presented the same issue shortly after *Gill* with the same holding by the Court.

### **ALJ Properly Considered Age in Catastrophic Designation Case**

The Court of Appeals of Georgia issued a decision in *Caswell, Inc. v. Spencer* on June 23, 2006, 2006 Ga. App. LEXIS 774, 2006 Fulton County D. Rep. 2136 (2006). In *Caswell*, the Claimant sustained a compensable back injury and sought to have it designated as catastrophic pursuant to O.C.G.A. § 34-9-200.1. A rehabilitation coordinator issued a decision finding his injuries to be catastrophic because his age, 62, rendered him unable to adapt to even light duty work and also due to other factors. Not agreeing with the administrative decision, the Employer and Insurer requested a hearing. The ALJ agreed and overturned the administrative decision, finding that the injuries did not warrant catastrophic designation. The ALJ also did not agree with the finding that the Claimant was unable to adapt to light duty work because of his age. The Appellate Division agreed. Next, the Claimant appealed the decision to Superior Court, asserting that the Board committed error by not considering his age when making a decision with regard to catastrophic designation. The Superior Court reversed the finding that the ALJ relied on an expert opinion which did not take into account the Claimant's age.

The Employer and Insurer appealed and the Court of Appeals granted discretionary review. The Court noted that, in accordance with a United States Supreme Court decision under a comparable federal

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provision, age is an appropriate factor to consider in determining whether jobs exist that an individual can perform. In this regard, the Court of Appeals reviewed the record, which clearly indicated that the ALJ did in fact consider the Claimant's age. Specifically, the Court noted that the ALJ considered testimony from a vocational specialist who testified that age is an important factor to consider when determining whether a person has the ability to perform a job. However, the vocational specialist disagreed with the assertion that someone who is 62-years-old is unable to learn and perform a new job. In addition, the specialist testified that many people of retirement age are returning to the workforce and that anyone can learn a new skill. In addition, the specialist estimated that there were approximately four million jobs in the economy that the Claimant could perform. The ALJ found this testimony to be more credible when compared to the testimony of the rehabilitation counselor indicating that the Claimant's age presented a barrier to learning a new job. Of note, the rehabilitation counselor's opinion was not based on any medical or psychological evidence, nor did the counselor perform any tests on the Claimant to support the opinion.

Consequently, the Court held that the Superior Court erred in remanding the case because the record indicated that age was considered by the ALJ.

#### **Catastrophic Designation for July 1, 1995, to June 30, 1997, Cases**

On July 13, 2006, the Georgia Court of Appeals decided *Rite-Aid Corp. v. Davis*, 2006 Ga. App. LEXIS 878, 2006 Fulton County D. Rep. 2412 (2006). In *Rite-Aid*, the Claimant sustained an injury to her neck and shoulder by a falling box which weighed in excess of 100 pounds. The Claimant sought to have her injury deemed catastrophic. At issue in this case

was the "catch-all" provision found at O.C.G.A. § 34-9-200.1(g)(6) as it existed in May 1996, the date of the Claimant's injury. Under that code section, an injury qualifies as catastrophic if it is "of a nature and severity that prevents the employee from being able to perform his or her prior work, or any work available in substantial numbers within the national economy." In 1997, this statute was amended with "or" being changed to "and," and inserting "for which such employee is otherwise qualified" after "national economy."

The ALJ deemed the Claimant's injury to be catastrophic because she presented sufficient evidence that she could not perform her prior work. The Claimant was, however, able to perform other jobs which were available in substantial numbers in the economy, but because the statute as written in May, 1996, did not require the two-pronged test, the Claimant was only required to meet one or the other. The Appellate Division reversed the ALJ's decision, finding that it was the legislature's intention to actually require both. The Superior Court reinstated the ALJ's decision, concluding that the statute was not ambiguous nor was there any evidence that the legislature had made a mistake in drafting it.

The Court of Appeals accepted the Employer's application for discretionary review. The Employer argued that it was the legislature's intent to require Claimants to prove: (1) they cannot perform their prior job and (2) they are unable to perform work which is available in the national economy in substantial numbers. The Employer argued that the legislature's intent in this regard is supported by the fact that the statute was amended in 1997; the change was made to correct the error as soon as possible; and the legislature could not have meant to make the burden of proving catastrophic designation any less than a Claimant seeking to prove temporary total disability.

The Court of Appeals discussed various statutory interpretation principles including the Georgia Supreme Courts directive that if the words of a statute "are plain and capable of having but one meaning, and do not produce any absurd, impractical, or contradictory results, then this Court is bound to follow the meaning of those words." In addition, the Court of Appeals noted that where a statute is susceptible to one and only one construction, "this Court cannot adopt a different construction merely to relieve [the] parties of some real or imagined hardship; but if the law is valid, we can only apply it in the form into which it was finally adopted as a statute of the lawmaking body."

As a result, the Court of Appeals affirmed the Superior Court's ruling that the Claimant's injury was properly designated as catastrophic because she had proven that she could not perform her prior job. According to the Court, this result was further supported by the Court's analysis of the three changes that were made to this statute from 1992 to 1997.

Alternatively, the Employer argued that the Claimant did not present sufficient evidence to support her contention that she could not perform her prior job or that she could not perform other jobs readily available in the economy. Again, the Court of Appeals disagreed and pointed out that it is bound to affirm factual findings of the Board if there is any evidence which supports the decision. In this case, the Claimant presented testimony supporting her contention from her treating physician as well as that of her vocational expert. As such, the Court of Appeals affirmed the findings of the ALJ.

Of note, Judge Bernes authored the dissenting opinion in this case and essentially argued that it was her belief that *the or should* be interpreted as *and* in order to avoid an absurd result. In addition, Judge Bernes stated that the effect of the majority's decision is to define a catastrophic injury

under the statute as it existed in 1996 as essentially the same as temporary total disability or, at worst *less stringently*. Judge Bernes' dissent was joined by Judge Andrews and Judge Johnson.

### **Suitable-Work Testimony Insufficient for Change in Condition Award**

On August 29, 2006, the Court of Appeals decided *Korner v. Education Management Corporation*, 2006 Ga. App. LEXIS 1089 (2006). In *Korner*, the claimant was employed as a clinical therapist and was attacked by one of her patients on February 21, 2001. The claimant sustained physical injuries, as well as psychological trauma. Although the physical injuries resolved, the claimant remained out of work following the accident and received TTD benefits, as she suffered from Post Traumatic Stress Disorder. In 2003, the employer requested a hearing seeking to show a change in condition for the better, pursuant to O.C.G.A. § 34-9-104(a). The ALJ ruled in favor of the employer, finding that the claimant had (1) experienced a change in condition for the better, (2) was capable of working, and (3) there was suitable work available (Id at 2). The Appellate Division determined that the employer met its burden with respect to the first two requirements only. The Appellate Division reversed, finding that the employer did not meet its burden of proving that suitable work was available to the claimant.

The Superior Court then reversed, finding that the Appellate Division erred when it ruled that the employer had not met its burden. The Court of Appeals granted the claimant's application for discretionary review and reversed the findings of the Superior Court. Essentially, the Court explained that the Appellate Division is authorized to substitute its own alternative findings of fact for those of the ALJ when there

is evidence in the record to support the alternative findings and, only if it determines that the ALJ's award is not supported by a preponderance of the evidence. Once the case is appealed from the Appellate Division, both the Court of Appeals and the Superior Court must view the evidence in a light favorable to the party prevailing before that division (Id at 4). Of course, the factual findings of the Appellate Division are binding when supported by any evidence.

As grounds for its decision, the Appellate Division found the employer's evidence for suitable jobs insufficient. Specifically, the employer presented witness testimony by a rehabilitation counselor (hereafter witness), who identified ten different jobs that she thought might be feasible. The witness was unaware of the claimant's job experience or any other relevant details as to whether she was fit to perform the proposed jobs. The Appellate Division rejected [the testimony] because [the witness] did not talk to [the claimant] or her treating physicians, and thus did not have enough information on which to base her report (Id at 6). Accordingly, the Court of Appeals found evidence to support the Appellate Division's determination and ruled that the Superior Court was not authorized to re-weigh the evidence.

### **Request for a Credit Not Raised Before Original Hearing Barred by Res Judicata**

On August 29, 2006, the Court of Appeals issued a decision in *Vought Aircraft Indus. v. Faulds*, 2006 Ga. App. LEXIS 1096 (2006). In *Vought*, the Claimant suffered an injury in April 2002 which was found to be compensable by an Administrative Law Judge (ALJ). The Employer did not appeal the award. In March 2003, the Claimant successfully requested that his injury be deemed catastrophic. The Employer requested a

hearing in 2005 asserting that: (1) the Claimant had undergone a change in condition for the better; (2) the Claimant's condition was no longer catastrophic; and (3) the Employer was entitled to a credit pursuant to O.C.G.A. § 34-9-243 for 20 weeks of wages he had received.

Following an evidentiary hearing, the ALJ declined all three requests and specifically found that the doctrine of *res judicata* barred the Employer from obtaining a credit under O.C.G.A. § 34-9-243. The Employer appealed and the Appellate Division of the Board reversed the ALJ decision, finding that the doctrine of *res judicata* was inapplicable. However, the Superior Court of Houston County reversed holding that *res judicata* did bar the request for credit. The Employer was granted discretionary review by the Court of Appeals, who affirmed the Superior Court's decision.

In arriving at its decision, the Court cited Board Rule 243, which sets forth that "the employer *shall* file a WC-243 with the Board no later than 10 days prior to a hearing." In addition, pursuant to O.C.G.A. § 9-12-40, "a judgment of a court of competent jurisdiction shall be conclusive between the same parties and their privies as to all matters put in issue or which under the rules of law might have been put in issue in the cause wherein the judgment was rendered until the judgment is reversed or set aside."

According to the pleadings, the Employer knew that the Claimant was "entitled to disability payments" during the same period that he received workers' compensation indemnity benefits. As such, the Employer was required to file a WC-243 requesting a credit 10 days prior to the original hearing in 2002. However, the Employer failed to comply with this rule and, consequently, was barred from seeking a credit at a subsequent hearing by the doctrine of *res judicata*.

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**O.C.G.A. § 34-9-202 Applies to ATP;  
Attorney Fees Assessed Against  
Employee**

Goswick vs. Murray County Board of Education, No. A06A1835, Ga. App. (September 1, 2006) cert. denied January 8, 2007. This case involved an employee whose benefits were suspended for refusal to undergo a physical examination by his authorized treating physician (ATP) pursuant to O.C.G.A. §34-9-202. The employee refused to undergo the examination requested by employer because he believed that O.C.G.A. §34-9-202 did not require him to undergo an employer requested examination by his authorized treating physician. Employer moved the Board to compel employee to undergo the examination. The ALJ found in favor of employer, and ordered the employee to undergo the examination. However, the employee refused to comply with the ALJ's order. The employer then moved for a suspension of benefits until the employee complied with the order, and further requested assessed attorney fees in prosecuting the motion. The employee again responded that this code section did not authorize the examination requested. The ALJ suspended the employee's disability benefits and awarded the employer assessed attorney fees. The Court of Appeals held that O.C.G.A. § 34-9-202 authorized the employer to require the employee to undergo an examination by his authorized treating physician, and that "blatant defiance of an ALJ order which he chose not to appeal was some evidence that [employee] defended the proceedings in part without reasonable grounds" which authorized the assessment of attorney fees against the employee.

**Co-Manager Was Not Co-Owner of  
Diner, Thus Entitled to Benefits**

Cypress Insurance Company v. Duncan, No. A06A1468. Ga. App.

(September 6, 2006). This case involved an "employee" who was a waitress and who had also sublet the employer's diner with her mother just prior to suffering a knee injury. The "employee" completed paperwork and bookkeeping for the diner in addition to occasionally waiting tables. The case is factually intensive, but the Court of Appeals found that there was some evidence which supported the Board's finding that employee was a co-manager and not a co-owner, which entitled her to benefits. Under these facts, if the employee was found to also be a co-owner, she would not have been entitled to benefits because she had not made an election with the insurance company to be covered as a partner/employee pursuant to O.C.G.A. §34-9-2.1

**Employee Not Required To  
Submit To WC/MCO IDR Prior To  
Requesting Change In ATP**

Metropolitan Atlanta Rapid Transit Authority v. Reid, No. A06A0996. Ga. App. (October 10, 2006), reconsideration denied December 14, 2006. This case involved MARTA's managed care organization's internal dispute resolution (IDR) and the employee's request for a change of authorized treating physician (ATP) under O.C.G.A. §34-9-200(b). The ALJ granted the employee's request for a change in ATP, and rejected employer's claim that employee was required to submit to internal dispute resolution (IDR) prior to requesting a change in ATP. The Board and Superior Court affirmed the decision, and it was appealed by employer. The Court of Appeals held that Board Rule 208(a)(1)(K)(i) requires that employee be allowed a one-time change of ATP within the managed care plan without first proceeding through the IDR. The Court also held that regardless of that Board Rule, the Board was authorized to interpret O.C.G.A. §34-9-200(b) as not requiring employee to exhaust

the dispute resolution process of the WC/MCO before petitioning the Board for a change in physician.

Importantly, on a matter of first impression, the Court held that the Board erred by exceeding its rule making authority, as a matter of law, in creating and applying an unpublished rule of appellate procedure, which deprived the employer of its statutory opportunity to have an ALJ reconsider his decision. The Court held that the employer was deprived of its statutory opportunity under O.C.G.A. §34-9-103(b) to move the ALJ for reconsideration of his ruling after an application for review had been filed, but that the error was harmless.

**Suicide Following Employee's Car  
Wreck Found Compensable**

Bayer Corporation et al. v. Lassiter, No. A06A0908. Ga. App. (November 9, 2006). This case involves an employee who suffered tinnitus from a work-related car wreck. The employee later committed suicide. The ALJ and the Board found that the employee's tinnitus resulted from the automobile accident, and they further concluded that "the tinnitus so deprived [employee] of his normal judgment that his suicide could not be considered intentional." Employer appealed trying to apply the standards of general negligence, including "foreseeability" to employee's suicide. The Court found that foreseeability was irrelevant, and that the threshold question was whether the tinnitus, rather than the suicide, proximately resulted from the accident. Once this determination was made, the issue then became whether the emotional and physical effects of the tinnitus caused the employee to be so devoid of his normal judgment that his conduct in taking his life could not be viewed as intentional under O.C.G.A. §34-9-17(a). The Court then affirmed the decision of the ALJ, the Board, and the Superior Court finding that

evidence supported their decision.

### **Superior Court Judge And County Sheriff Not Co-Employees Under Workers Compensation Act**

Freeman v. Barnes, No. A06A1627. Ga. App. (November 9, 2006). This case involved whether a Superior Court judge and a county sheriff were co-employees so as to bar a negligence claim under the exclusive remedy provision of the Workers' Compensation Act. The facts were that the Superior Court judge was murdered while sitting on the bench by an inmate who escaped from the deputy sheriff who was guarding him. The judge's widow brought a claim for gross negligence against the Fulton County Sheriff, and several deputy sheriffs. The sheriff answered and moved to stay the proceedings and dismiss the complaint on the grounds that the Superior Court judge and the sheriff were co-employees of Fulton County and of the State, thus barring the claim by the exclusive remedy provision of the Workers' Compensation Act. In a long opinion, the Court held that the Superior Court judge was a state employee and not a county employee for workers' compensation purposes; that the county sheriff was a county employee and not also a state employee for workers' compensation purposes; that the widow's acceptance of payment of the funeral bill by the county did not constitute "acceptance" of workers' compensation benefits as contemplated under the Workers' Compensation Act; and that the county was not authorized to provide workers' compensation coverage to Superior Court judges, as they are state employees even though they may receive a county supplement. Thus, the judge's widow's negligence complaint was not barred by the exclusive remedy provisions of the Workers' Compensation Act and summary judgment was denied.

### **Occupational Disease/Asbestos**

### **Claim With Last Exposure In 1993 Found Compensable**

Putzel Electric Contractors v. Jones. No. A06A1039. Ga. App. (November 22, 2006). This claim is an asbestos occupational disease case where the employee was last exposed in 1993, but was not definitively diagnosed until May of 2003, and the claim was filed September 23, 2003. From 1993 forward the employee was treated on several occasions for breathing-related complaints. However, the ALJ found that employee was diagnosed with asbestosis on August 14, 2003, and that his claim was properly filed within one year from that date. The Board found that employee was diagnosed in May of 2003, but that the error was harmless in that the claim was filed within one year of the May 2003 date as well. The Court affirmed the ALJ's decision and found that it was not outcome determinative under the facts of this case whether the statute of limitations began to run at the time employee first learned of the causal connection between his exposure to asbestos and his resulting disease, or whether it began to run when he was first diagnosed by a physician. Both occurred in 2003, rendering his claim, filed in September 2003, timely. The Court did not offer an opinion as to when that statute of limitations actually began to run. Of note is that the employee was a pack-a-day smoker for nearly 40 years, and the only evidence of asbestos exposure was offered by the employee and a co-worker identifying the substance as asbestos, and their testimony that it was removed while they were working on a project in 1993.

### **"Off Duty" Sheriff Found To Be In Course And Scope Of Employment**

Stevenson v. Ray, No. A06A1880. Ga. App. (November 30, 2006). This case involved an "off duty" sheriff's deputy who was responding to a call in a marked patrol car after being told

by his supervisor that his presence was not needed. The officer stated that he continued the pursuit in order to "back up" his fellow officers. This officer collided with a fellow officer causing injury to the other officer. The other officer brought a negligence claim which was held to be barred by the exclusive remedy provision of the Workers' Compensation Act because the "off duty" officer's actions "cannot be described as private and personal" and "were an attempt to assist his fellow officers in their lawful duty." The Court determined that this was in the course and scope of his employment. Thus, the Court upheld the Superior Court's grant of summary judgment to the injured officer's co-employee barring the negligence claim.

### **Employer Failed To Notify WC Insurance Carrier, Appear At ALJ Hearing, Respond To ALJ "Show Cause" Order, Appeal Adverse Award, Thus Denied Relief Through It's Motion To Set Aside ALJ's Order**

Winnersville Roofing Company v. Coddington. No. A07A0439. Ga. App. (December 19, 2006). This case involves an employer who received three separate notices of hearings before an ALJ, failed to inform his insurance company of the hearing notices, failed to respond to the ALJ's "show cause" order, instructing it to provide evidence of insurance, failed to appear at the hearing, and failed to appeal the ALJ's award of total disability benefits to employee, which resulted in additional 10% in benefits for failure to have insurance, 25% assessed attorney fees, and a civil penalty of \$2,000.00. When employee filed in Superior Court to enforce the ALJ's award pursuant to O.C.G.A. §34-9-106, employer moved to have the ALJ's award vacated and set aside pursuant to O.C.G.A. §9-11-60(d)(2). The Superior Court found that employer had received proper notice of the ALJ's hearing, and had

*continued next page*

therefore acted negligently in failing to appear. Thus, the Superior Court granted the employee's motion to enforce the ALJ's award. The Court of Appeals rejected the employer's argument that the ALJ's award was not supported by sufficient, competent evidence, because employer could have appealed the ALJ's award on these grounds, and failed to do so. Employer's second ground for appeal was that employer's insurance carrier was not named in the workers' compensation claim, and that the ALJ erroneously found that the employer had no insur-

ance. The Court held that the employer had ample notice and opportunity to participate in the ALJ's hearing, and to file an appeal as provided by law. The employer's fault or neglect led to the finding of no insurance, and to the absence of the insurance company as a party. The Court found that the Superior Court properly held that as movant, employer could not assert this ground in a motion to set aside because the harm was caused, at least partly by its own neglect.

## Appendix A

### 2006 Summary of Legislative Changes

#### **HB 1240 Workers' Compensation**

This 2006 workers' compensation bill comes from the State Board of Workers' Compensation Advisory Council's Legislative Committee. The Legislative Committee is comprised of leaders from all aspects of workers' compensation--insurance, labor, medical, legal, small business, and business.

The Advisory Council's Legislative Committee met on several occasions throughout the year and discussed a number of issues. The Committee came to a consensus on the following amendments:

#### **Amend O.C.G.A. §34-9-104:**

This section has been modified slightly to make its wording consistent with the wording found in other sections. The prior language provided that the employee shall receive notice from the employer. The new language provides that the employer shall send notice to the employee.

#### **Amend O.C.G.A. §34-9-203:**

This section has been amended to clarify existing law regarding the time limit for submitting requests for mileage reimbursement to make it clear that the injured worker has one year from the date incurred to submit mileage expenses, just as medical provider must submit charges to the employer/insurer within one year of the date of service.

#### **Amend O.C.G.A. §34-9-265:**

This section has been amended to increase the maximum cap on death benefits from \$125,000.00 to \$150,000.00 for the surviving spouse who is the sole dependent at the time of an employee's death. This cap had not been raised since July 1, 2000. (These benefits are paid in a weekly amount, based on the weekly rate the injured worker would receive for Temporary Total Disability.)

#### **Delete O.C.G.A. §43-1B-7:**

This deletion removed the workers' compensation exception from the Patient Self-referral Act of 1993. The purpose of that Act, as expressed by the General Assembly, was to remove the potential conflict of interest that is raised when one health care provider refers a patient to a second provider for other health services where the first provider has a financial interest in the second provider. The intent was to address referral practices which "may limit or eliminate competitive alternatives in the health care services market...result in over utilization.....increase costs to the health care system...and adversely affect the quality of health care."

All provisions of Title 43-1B have now been in effect for 10 years, and apply to all health care providers. These activities are also governed by federal law. There are a number of exceptions to the provisions, including rural areas and instances where there is not another suitable entity or facility in the community. Additionally, the provisions do not apply to group practices and self-contained facilities.

Workers' compensation providers had been subject to one part of the provisions of Title 43-1B, but not all. The recommendation was that there was no reason to continue the exemption and that the rules governing treatment of all other patients should also apply when the provider is treating a workers' compensation patient.

## **HB 1405 (Subsequent Injury Trust Fund)**

Although this legislation was not requested by the Board's Advisory Council, it is included in this summary because of its impact on the workers' compensation system. This legislation was requested by the Trustees of the Subsequent Injury Trust Fund (SITF) and places time limits on the employer/insurer for perfecting a claim and obtaining a reimbursement agreement with the SITF.

### **Amend O.C.G.A. §34-9-362:**

Under the new provisions, for those notices of claim that were filed with the SITF on or before July 1, 2006, the employer/insurer shall have until June 30, 2009 to obtain a reimbursement agreement issued by the SITF or the claim for reimbursement shall be deemed automatically denied.

For those notices of claim that are filed with the SITF after July 1, 2006, the employer/insurer shall have three years from the date the notice was received by the SITF to obtain a reimbursement agreement issued by the SITF or the claim for reimbursement shall be deemed automatically denied.

For those cases where the compensability of the underlying workers' compensation claim is at issue before the State Board of Workers' Compensation, the employer/insurer shall have three years from the date of final adjudication of compensability (by the State Board of Workers' Compensation or any appellate court) to obtain a reimbursement agreement issued by the SITF or the claim for reimbursement shall be deemed automatically denied.

## **Appendix B**

### **SUMMARY OF THE AMENDMENTS TO THE RULES OF THE STATE BOARD OF WORKERS' COMPENSATION**

The 2006 Rules, effective July 1, 2006, contain organizational, editorial, and substantive changes. This summary is intended as a convenient reference and does not represent an exhaustive description of all rules changes. For detailed information regarding a change(s) to a particular rule, please refer to the published version of the rule.

#### **Rule 15:**

Amended section (e) to clarify this section. (p. 3)

Amended section (f) to require a Form WC-1 when filing a "no-liability" stipulation and agreement. (p. 3).

#### **Rule 61:**

Amended (b)(1) to require an insurer or self-insurer to place their SBWC ID number on the Form WC-1 when filing it with the Board. (p. 7). The SBWC ID numbers are located on the Board's web page at [www.sbwc.georgia.gov](http://www.sbwc.georgia.gov).

In addition, section (b)(1) was amended to state a Form WC-1 may be rejected if it does not include the name and address of the employee, employer, insurer, self-insurer, or group self-insurer, date of injury, the employee's social security number, the insurer's, self-insurer's, or group/self-insurer's SBWC ID number, or if sections B, C, or D are not completed. (p. 8).

Amended (b)(2) to clarify a Form WC-2 must be filed when paying benefits under O.C.G.A. §34-9-261, O.C.G.A. §34-9-262, or O.C.G.A. §34-9-263. (p. 8).

Amended (b)(10)(Form WC-14), (b)(11)(Form 14A), (b)(25)(Form WC-121) (b)(28)(Form WC-200a), (b)(36)(Form WC-240), & (b)(37)(Form WC-240A). (pp. 9-12).

At (b)(26), the sections are renumbered due to the additions of 4 new forms and 2 new sections. (p. 11). The new forms are: The Permit to Write Insurance and corresponding Permit to Write Insurance Update, which are located at (b)(26) & (b)(27), and the Rehabilitation Supplier application and corresponding renewal, which are located at (b)(48) & (b)(49). (pp. 11-14).

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New (b)(54) requires that all forms be filed on the most current version. (p. 14). Failure to use the current version may result in rejection by the Board.

New (b)(55) permits service of a form with an ICMS equivalent. (p. 15).

**Rule 100:**

Section (f) concerning confidentiality for mediations was rewritten. (p. 16).

Section (g) was amended regarding attendance at mediations. (p. 16).

Section (h) concerning postponement procedures for mediations was rewritten. (pp. 16-17).

New section (i) was created to strongly discourage misconduct during mediations. (p. 17).

**Board Rule 102:**

New sections (A)(2) and (A)(3) were created. (p. 17).

Section (A)(2) was created to follow the Uniform Superior Court's rule concerning Admission Pro Hac Vice. (p. 17).

Section (A)(3) was created to require attorneys to place their Georgia bar number on all filings, and to use the current versions of forms. (p. 17). Failure to use the current version may result in rejection by the Board.

Section (C)(1) was amended to clarify procedures regarding postponements of hearings. (p. 18).

Section (D)(1) was amended to limit motions to 50 pages. (p. 18).

Section (E)(3)(b) was amended to clarify the remedies available under this section. (p. 19).

Section (E)(4) was amended to limit hearing briefs to 30 pages. (pp. 19-20).

Section (E)(7) was created to permit the Board to send Notices of Hearing by electronic mail. (p. 20).

**Board Rule 108:**

This rule was amended to require claimant attorneys to include on attorney fee contracts the following information: 1) name, (2) bar number, (3) firm name, (4) address, (5) phone number, (6) fax number, (7) email address, and (8) Board claim number. All contracts shall include the employee's name and address. (p. 23).

Section (b)(8) was created to clarify this rule. (p. 25).

**Board Rule 200:**

Section (b)(1) was amended to limit change of physician requests to 50 pages. (p. 29).

**Board Rule 200.1:**

Section (e)(2)(iv) was amended to allow objections to rehab plans to be twenty days. (p. 36).

Section (e)(3) was amended to clarify attendance at rehabilitation conferences. (pp. 36-37).

Section (f)(2)(i) was amended to not require academic transcripts or professional licenses when registering as a rehabilitation supplier. (p. 37).

Section (f)(2)(iii) was amended to strike "Director of Licensure & Quality Assurance" and replace with "Board." (p. 38).

Section (f)(4)(ii) was amended to strike "Director of Licensure & Quality Assurance" and replace with "Board." (p. 39).

**Board Rule 202:**

Section (a) was amended to clarify this section. (p. 44).

**Board Rule 203:**

Section (e) was amended to raise the mileage reimbursement rate to 40 cents. (p. 46).

**Board Rule 221:**

Section (c) was rewritten for clarification. (p. 57).

**FORM CHANGES:**

The Board has updated the Board's forms in light of our exciting upcoming ICMS paperless system. As such, when the new forms are available, please review each of them. Until approved and published, please continue to use existing forms.

**Appendix C**

07 LC 36 0471

House Bill 424

By: Representatives Coan of the 101<sup>st</sup>, Reese of the 98<sup>th</sup>, Hamilton of the 23<sup>rd</sup>, Cox of the 102<sup>nd</sup>, Carter of the 159<sup>th</sup>, and others

**A BILL TO BE ENTITLED  
AN ACT**

To amend Chapter 9 of Title 34 of the Official Code of Georgia Annotated, relating to workers' compensation, to provide for the dismissal of certain claims in which no hearing has been held after a certain time period; to extend the period of time in which the employer has to select a rehabilitation supplier; to specify that examinations of the employee may include physical, psychiatric, and psychological examinations; to provide that charges for prescriptions and charges for other items and services shall be subject to the approval of the State Board of Workers' Compensation; to increase the weekly wage amounts for compensation for total disability; to increase the maximum weekly benefit for compensation for temporary partial disability; to provide for related matters; to repeal conflicting laws; and for other purposes.

**BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:**

**SECTION 1.**

Chapter 9 of Title 34 of the Official Code of Georgia Annotated, relating to workers' compensation, is amended by revising Code Section 34-9-100, relating to the filing of claims with the State Board of Workers' Compensation and the dismissal of stale claims, as follows:

"34-9-100.

(a) Subject to Code Section 34-9-82, a claim for compensation may be filed with the board at any time following an injury or death. The board and its administrative law judges shall have full authority to hear and determine all questions with respect to such claims.

(b) The board shall make or cause to be made any investigation or mediation it considers necessary and, upon its own motion or application of any interested party, order a hearing thereon and assign the claim to an administrative law judge for review. Furthermore, the board may direct the parties to participate in mediation conducted under the supervision and guidance of the board.

(c) ~~On or after July 1, 1985,~~ Any application for hearing filed with the board pursuant to this Code section, on or after July 1, 1985, but prior to July 1, 2007, for which no hearing is conducted for a period of five years shall automatically stand dismissed.

(d)(1) For injuries occurring on or after July 1, 2007, any claim filed with the board for which neither medical nor income benefits have been paid shall stand dismissed with prejudice by operation of law if no hearing has been held within five years of the alleged date of injury.

(2) This subsection shall not apply to a claim for an occupational disease as defined in Code Section 34-9-280.

(3) The form provided by the board for use in filing a workers' compensation claim shall include notice of the provisions of this subsection.

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(e) Any claim, notice, or appeal required by this chapter to be filed with the board shall be deemed filed on the earlier of: (1) the date such claim or notice is actually received by the board; or (2) the official postmark date such claim or notice was mailed to the board, properly addressed with postage prepaid, by registered or certified mail or statutory overnight delivery."

#### **SECTION 2.**

Said chapter is further amended by revising subsection (a) of Code Section 34-9-200.1, relating to rehabilitation benefits and rehabilitation suppliers, as follows:

"(a) In the event of a catastrophic injury, the employer shall furnish the employee entitled to benefits under this chapter with reasonable and necessary rehabilitation services. The employer either shall appoint a registered rehabilitation supplier or give reasons why rehabilitation is not necessary within 48 hours of the employer's acceptance of the injury as compensable or notification of a final determination of compensability, whichever occurs later. If it is determined that rehabilitation is required under this Code section, the employer shall have a period of 15 20 days from the date of notification of that determination within which to select a rehabilitation supplier. If the employer fails to select a rehabilitation supplier within such time period, a rehabilitation supplier will shall be appointed by the board to provide services at the expense of the employer. The rehabilitation supplier appointed to a catastrophic injury case shall have the expertise which, in the judgment of the board, is necessary to provide rehabilitation services in such case."

#### **SECTION 3.**

Said chapter is further amended by revising subsections (a) and (e) of Code Section 34-9-202, relating to an examination of an injured employee, as follows:

"(a) After an injury and as long as he claims compensation, the employee, if so requested by his employer, shall submit himself to examination, at reasonable times and places, by a duly qualified physician or surgeon designated and paid by the employer or the board. Such examination may include physical, psychiatric, and psychological examinations."

"(e) Notwithstanding the rights afforded an employee under Code Section 34-9-201, the employee, after an accepted compensable injury and within 120 days of receipt of any income benefits, shall have the right to one examination at a reasonable time and place, within this state or within 50 miles of the employee's residence, by a duly qualified physician or surgeon designated by the employee and to be paid for by the employer. Such examination, of which the employer or insurer shall be notified in writing in advance, shall not repeat any diagnostic procedures which have been performed since the date of the employee's injury unless the costs of such diagnostic procedures which are in excess of \$250.00 are paid for by a party other than the employer or the insurer. Such examination may include physical, psychiatric, and psychological examinations."

#### **SECTION 4.**

Said chapter is further amended by revising subsection (a) of Code Section 34-9-205, relating to board approval of physician's fees, hospital, and other charges, as follows:

"(a) Fees of physicians, and charges of hospitals, charges for prescription drugs, and charges for and other items and services under this chapter shall be subject to the approval of the State Board of Workers' Compensation. No physician, hospital, or other provider of services shall be entitled to collect any fee unless reports required by the board have been made."

#### **SECTION 5.**

Said chapter is further amended by revising Code Section 34-9-261, relating to compensation for total disability, as follows:

"34-9-261.

While the disability to work resulting from an injury is temporarily total, the employer shall pay or cause to be paid to the employee a weekly benefit equal to two-thirds of the employee's average weekly wage but not more than ~~\$450.00~~ \$500.00 per week nor less than ~~\$45.00~~ \$50.00 per week, except that when the weekly wage is below ~~\$45.00~~ \$50.00, the employer shall pay a weekly benefit equal to the average weekly wage. The weekly benefit under this Code section shall be payable for a maximum period of 400 weeks from the date of injury; provided, however, that in the event of a catastrophic injury as defined in subsection (g) of Code Section 34-9-200.1, the weekly benefit under this Code section shall be paid until such time as the employee undergoes a change in condition for the better as provided in paragraph (1) of subsection (a) of Code Section 34-9-104."

#### **SECTION 6.**

Said chapter is further amended by revising Code Section 34-9-262, relating to compensation for temporary partial disability, as follows:

"34-9-262.

Except as otherwise provided in Code Section 34-9-263, where the disability to work resulting from the injury is partial in character but temporary in quality, the employer shall pay or cause to be paid to the employee a weekly benefit equal to two-thirds of the difference between the average weekly wage before the injury and the average weekly wage the employee is able to earn thereafter; but not more than ~~\$300.00~~ \$334.00 per week for a period not exceeding 350 weeks from the date of injury."

#### **SECTION 7.**

All laws and parts of laws in conflict with this Act are repealed.

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