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Language Barriers: Court Addresses Medical Necessity

By: Matt Colon, Associate, Miami

The State of Florida enjoys the privilege of being among the most ethnically and linguistically diverse in the nation. In cities such as Orlando, Tampa, and Miami, it is not uncommon for one's ear to catch a chord or two of Spanish, Portuguese, or Creole within the course of a single supermarket stroll. Of course, Florida's diversity presents its share of difficulty, not to mention expense, when it comes to adjusting and litigating claims. Events such as claimant and employer contact, depositions, mediations, hearings, and medical appointments frequently require translation services, a trend which will likely continue as Florida's diversity grows.

Though costly, translation services at appointments allow us to maintain control of a claim, as we can send an injured worker to a known provider without having to take a gamble on an unknown same-language provider. But what happens when an authorized provider refers the claimant to a provider that speaks the same language as the worker under the label of "medical necessity"?

In Trejo-Perez v. Arry's Roofing, 141 So.3d 220 (Fla. 1st DCA 2014), the Court set an extremely high bar for such a provision to be required from an Employer/Carrier. Mr. Trejo-Perez suffered a closed head injury after falling 30 to 40 feet from a ladder. He was treated by a neurologist who referred the claimant to a Spanish-speaking psychologist. Testimony from the neurologist revealed that he believed a Spanish-speaking psychologist was medically necessary due to the nature of a psychological evaluation, as it requires heavy communication, and risks miscommunication. Id. After the JCC denied the claimant's request for a Spanish-speaking psychologist, the issue was appealed to the First DCA. The majority of the Court established that a finding of medical necessity relies on the substance of the evidence rather than the use of "magic words." Id. at 222. Second, the Court acknowledged the JCC's authority to reject even unrebutted medical testimony where there is a reasonable evidentiary basis to do so. Finally, the Court found that the referral to a Spanish-speaking psychologist did not amount to "medical necessity" but was merely preferential. Id.

The concurring opinion in Trejo-Perez called special attention to the "prevailing practice parameters in the provision of health care services and psychiatric services specifically." Id. at 226. It was found that the record did not address whether the field of psychology has adopted as a "widely accepted practice" that patients are entitled to a primary-language speaking psychologist and found further that the provision of a qualified psychologist and interpreter "met the prevailing standard of care." Id. From this language, we can interpret that as long as the use of an interpreter remains the prevailing standard in the community, a claimant is not automatically entitled to a primary-language speaking provider.

So far, JCC opinions have stood by the Trejo-Perez decision (see OJCC Case No.: 11-19606SHP), keeping the lid closed on what could have been a tremendous, if not impossible, burden on claims management across the state.

Spoliation of Evidence in Georgia: When You Should Know Better, You Must Do Better

By: LeRyan Paige Lambert, Associate, Atlanta

Possibly the most famous quote by the great Maya Angelou is, "[w]hen you know better, you do better." The Georgia Supreme Court and appellate courts have most recently confirmed and expanded Georgia spoliation law to: when you know better, or should know better, you MUST do better.

In Georgia, spoliation was consistently defined as the destruction of evidence or failure to preserve evidence that is necessary to "contemplated or pending litigation." See Silman v. Associates Bellemeade, 286 Ga. 27 (2009). Over the years, great debate and varying Georgia laws have danced around defining when litigation is sufficiently "contemplated or pending," so as to create the duty to preserve evidence. Georgia courts have attempted to assure that simply because someone is injured, *without more*, there is not a duty to preserve evidence. See Whitfield v. Tequila Mexican Rest. No. 1, 323 Ga. App. 801, 806-807 (2013); see also Allen v. Zion Baptist Church of Braselton, 328 Ga. App. 208 (2014); Silman v. Associates Bellemeade, 286 Ga. 27 (2009) (potential liability does not equate to contemplated litigation).

But, what is "more"?

This summer, the Georgia Supreme Court took lead on this dance, and acknowledged that the mere language "contemplated or pending" provides parties little guidance. See Phillips v. Harmon, Case S14G1868, pp. 18-20 (Ga. June 29, 2015). It then expanded Georgia's spoliation definition from which it and lower Georgia courts have long worked and asserted, "[l]ogically, the duty to preserve relevant evidence must be viewed from the perspective of the party with control of the evidence and is triggered not only when litigation is pending but when it is *reasonably foreseeable* to that party." Id. at 19 (emphasis added).

With this new "reasonably foreseeable" standard, the Phillips court added a host of considerations that can create sufficient constructive notice of a non-spoliation duty. These include: the type and extent of the injury; the clarity of each party's fault; the relationship and course of conduct between the parties; the frequency with which litigation occurs in similar circumstances; subsequent party actions (i.e. notification to insurers and attorneys); and, investigations of a party indicating any anticipation of litigation. Phillips v. Harmon, pp. 20-22.

From a civil or workers' compensation defense perspective, this new standard may be a double-edged sword. Insurers have long been held to a heightened duty to preserve evidence since they are experienced in litigation and claims handling procedures. See R.A. Siegel Co. v. Bowen, 246 Ga. App. 177 (2000). See also Chapman v. Auto Owners Ins. Co., 220 Ga. App. 539, 542 (1996). Thus, not much has changed for many of our insurers. However, our insured clients (insured employers, companies, and potentially even individuals) can now themselves be held to a higher standard if a case's broad nature, facts, or something specific to the defendant causes litigation to be reasonably foreseeable to the subject spoliator--both before an insurer is ever involved and even before a claim is ever made. On the other hand, the Phillips decision opens up room to argue the same against others who were before not subject to heightened duty. Depending on a case's facts, plaintiffs, especially but not limited to, those represented at the time of destroying possible evidence, or possibly even co-defendants (insured or not) who destroy evidence that may have been useful to our client's defense are now more exposed to the duty to preserve.

Finally, these considerations not only increase one's duty, but also may elevate sanctions. It is important to remember that neither bad faith nor even intentional spoliation is required for ultimate exclusionary sanctions. AMLI Residential, 293 Ga. App. 358, 363 (2008). Instead, trial courts are to "weigh the degree of the spoliator's culpability against the prejudice to the opposing party" in applying sanctions. Flury v. Daimler Chrysler Corp., 427 F.3d 939, 946 (11th Cir. 2005). In weighing culpability to determine whether sanctions were appropriate, the AMLI court distinguished "'the accidental, random, or unintended dissipation of evidence by person having no interest in its preservation,' [from] those cases where 'a party knowledgeable of litigation strategy, tactics, and policies who invokes the aid and jurisdiction of the Court and its processes . . . acted unfairly to preclude the opportunity of an adversary to be apprised of the existence of a defense to a [party's] claims.'" AMLI Residential, 293 Ga. App. 358, 363 (2008). (citing Northern Assurance Co. v. Ware, 145 F.R.D. 281 (D.Me. 1993)). The distinction made by the AMLI court in considering sanctions is almost *identical* to that utilized by the Bowen and Chapman courts in heightening the duty of practiced insurer litigants. With this prior parallel application of duty and sanction examinations, now that Georgia law has expanded its duty assessment to include the above noted considerations, it is reasonably foreseeable that these will also naturally be extended in weighing culpability.

Walking Through the Independent Contractor Analysis, or Could We Take Uber Instead?

By: Fred Vitale, Associate, Orlando

Most of us have heard of the company Uber, and many have probably even used Uber at some point for transportation. A recent Florida unemployment decision involved a former Uber driver who was found by Department of Economic Opportunity to be an employee of the company, not an independent contractor for purposes of unemployment compensation. See Robert W. Wood, *Florida Says Uber Drivers Are Employees, But FedEx, Other Cases Promise Long Battle*, FORBES, (May 26, 2015), http://www.forbes.com/sites/robertwood/2015/05/26/florida-says-uber-drivers-are-employees-but-fedex-other-cases-promise-long-battle/. Does this mean they would also be an employee under workers' compensation?

We all know employers must secure and maintain compensation for their employees including "all private employments in which four or more employees are employed by the same employer or, with respect to the construction industry, all private employment in which one or more employees are employed by the same employer." Fla. Stat. 440.10(1)(a) & 440.02 (17)(b)(2). However, "employee" excludes independent contractors who are not engaged in the construction industry. Fla. Stat. 440.02(15)(d)(1).

Florida Statute 440.02(15)(d)(1)(a) lists certain criteria for an individual to qualify as an independent contractor. To be considered an independent contractor, the claimant has to meet at least four of the following six conditions: maintaining a separate business, holding/applying for a federal employer identification number, having compensation paid to a business rather than an individual, holding business bank accounts, performing work at his own election, or receiving compensation through a contractual agreement. Even if the claimant does not meet four of those requirements, he can still be presumed to be an independent contractor based on satisfying any of the points outlined in Florida Statute 440.02(15)(d)(1)(b). These include elements such as incurring principal expenses related to the service performed, realizing profit or suffering loss in connection with the work, and continuing/recurring business liabilities or obligations. Fla. Stat. 440.02(15)(d)(1)(b).

So, what about an Uber driver? You might think that section 440.02(15)(d)(10), Florida Statutes would dispatch of that inquiry. This section specifically states the definition of employees does not include: "a taxicab, limousine, or other passenger vehicle-for-hire driver who operates said vehicles pursuant to a written agreement with a company which provides any dispatch, marketing, insurance, communications, or other services under which the driver and any fees or charges paid by the driver to the company for such services are not conditioned upon, or expressed as a proportion of, fare revenues." Fla. Stat. §440.02(15)(d)(10). However, Uber claims to be a technology company which "just takes a fee for putting passengers and drivers together." See Wood. According to their terms and conditions, "Uber does not provide transportation or logistics services or function as a transportation carrier." https://www.uber.com/legal/usa/terms.

Uber's website claims to be "evolving the way the world moves," but could they also evolve the workers' compensation independent contractor analysis? https://www.uber.com/about. That is doubtful, but it remains to be seen. With Uber's popularity continuing to rise, we may see an Uber driver taken through the Florida workers' compensation independent contractor analysis in the very near future.

**Special thanks to legal intern, Sean Butler, for his contribution to the article.

Advances—Is there a Changing Tide?

By: Ya'Sheaka Campbell Williams, Partner, Tampa

"[A]ny order requiring payment of money to claimant in the absence of a petition would be either a loan or a gift." JCC Lorenzen, in Canady v. Industrial Staffing, Ltd. (15-006420EHL)

Fla. Stat. 440.20(12)(c) provides in pertinent part:

> In the event the claimant has not returned to the same or equivalent employment with no substantial reduction in wages or has suffered a substantial loss of earning capacity or a physical impairment, actual or apparent:
> 1. An advance payment of compensation not in excess of $2,000 may be approved informally by letter, without hearing, by any judge of compensation claims or the Chief Judge.
> 2. An advance payment of compensation not in excess of $2,000 may be ordered by any judge of compensation claims after giving the interested parties an opportunity for a hearing thereon pursuant to not less than 10 days' notice by mail, unless such notice is waived, and after giving due consideration to the interests of the person entitled thereto.

After the First DCA's opinion in Lopez v. Allied Aerofoam, 48 So.3d 888 (Fla. 1st DCA 2010), granted an advance to a claimant in a denied claim, claimants have requested advances quite frequently. Because of this case, many carriers provided advances without question. ESIS was one of the first carriers to reject the notion that advances must be provided absent good cause, and gave the First DCA the chance to outline a 2 step inquiry to guide carriers and JCCs on advance determinations. First, the claimant must fall into one of three statutory categories: 1) has not returned to same or equivalent employment with no substantial reduction in wages; 2) has suffered a substantial loss in earning capacity; or 3) has suffered a physical impairment. Second, the JCC must find that the claimant is a proper claimant and has provided justification for the request. Finally, the court opined that as the statute is discretionary, a claimant is never entitled to an advance, but is only eligible to be considered for one. ESIS/ACE v. Kuhn, 104 So.3d 1111 (Fla. 1st DCA 2012).

In Canady v. Industrial Staffing, Ltd., the claimant filed a Motion for Advance of $1,500.00 in July of 2015. The Employer/Carrier filed a Response to the Motion for Advance, raising defenses that the claimant had reached MMI, nor was there a nexus between the claimant's motion and the benefits being sought via a petition for benefits. On July 30, 2015 Judge Lorenzen denied the claimant's request for an advance after concluding that as a matter of law, the claimant was not a proper "claimant." In fact, Judge Lorenzen found that the proper "claimant" for the purposes of an advance is an injured employee who has filed a petition for benefits, not just a petition requesting an advance. Further, Judge Lorenzen clarified that the filing of a petition for benefits transforms the injured employee into a claimant who may seek an advance. Finally, Judge Lorenzen held that she lacked jurisdiction over the Employer/Carrier to order an award of an advance as there were no pending petitions.

At this point, the case is persuasive authority, as it is a JCC decision, but may be used to defend those requests for advances when there are no other outstanding issues. The injured employee may not be entitled to an advance if there is no pending petition for benefits.

News from the Medicare Compliance Department

By: Vanessa Lipsky, Partner, Miami

Effective October 1, 2015, Medicare will be converting from the use of ICD-9 codes (diagnosis codes) to the more descriptive ICD-10 codes. This change is being mandated nationwide and will result in ICD-9 codes becoming obsolete. Medicare Set-Asides and Section 111 reporting all require associated ICD codes for proper identification and tracking. If you have an MSA that will be submitted after October 1, 2015, it should be updated to comply with Medicare's change and avoid delay in the review process. Our department is equipped and prepared for the transition from 9 to 10 codes and can expeditiously update your MSAs for compliance.

As a reminder, our Medicare Compliance Department assists with all aspects of MSP compliance, which includes identifying, negotiating and resolving conditional payment liens. Further, when preparing for settlement negotiations on a file with Medicare implications, our department can assist with identifying MSP compliance considerations and obtaining annuity quotes and rated ages to reduce the cost of the MSA. The Compliance Department also handles Medicaid compliance to include disputes regarding Medicaid liens.

Please contact Vanessa Lipsky, vlipsky@eraclides.com, for all of your Medicare/Medicaid needs.