ERACLIDES GAZETTE

What's Inside?

New Twist to Prevailing Party Costs Established by the First DCA

By: Michael Quiggins, Partner, Tallahassee

The First DCA issued another curious decision in the claimant's favor on December 28, 2015 in Jennings v. Habana Health Care Center, (1D15-1749) which essentially exposes the employer/carrier to pay litigation costs to the claimant for benefits it authorizes on a timely basis, if they are provided after the Petition for Benefits has been filed. This decision has been discussed in many workers' compensation circles in the last few weeks. After seeing the oral arguments held on November 17, 2015, I was quite surprised at the published decision. According to the facts of the Jennings case, the claims adjuster took prompt action and authorized the benefits on a timely basis. Based on the Court's contrary ruling in regard to prevailing party costs, I sympathize with the prudent adjuster trying to do their job and furnish benefits quickly and efficiently under the allegedly self executing nature of the Florida workers' compensation system.

Ms. Jennings sustained a compensable injury on September 2, 2014, when a window awning fell on her while working. Habana Health Care authorized and provided medical attention that same day, and the PCP referred the claimant to an orthopedic specialist, following x-rays that revealed a shoulder fracture. On September 9, 2014, a week later, a Petition for Benefits was filed seeking authorization of the orthopedic specialist. The adjuster authorized an orthopedist on September 12, 2014, and notified the claimant's attorney that the scheduled appointment would take place three days later on September 15, 2014.

The JCC ruled that the claimant was not entitled to costs as she was not the prevailing party. The JCC found that the E/C response was timely pursuant to FS 440.192(8) which provides that the E/C must pay the requested benefits or shall file a response to the PFB within 14 days upon receipt. The JCC also ruled the E/C response was timely under FS 440.34(3), the 30 day attorney fee portion of that provision, since the E/C clearly authorized the requested benefit within 30 days from the receipt of the Petition.

However, the First DCA determined the JCC misread the statutory provisions, conflating attorney's fees and costs. The DCA found that although attorney's fees and costs are routinely claimed, and not infrequently denied the entitlement to costs is a distinct issue, separate and apart from entitlement to attorney's fees. The DCA found FS 440.192(8) and 440.34(3) (the 30 day attorney fee language in which the JCC relied) were irrelevant and did not apply to prevailing party costs. The DCA pointed out that the prevailing party costs section of FS 440.34(3) states "If any party should prevail in any proceeding before a [JCC]….there shall be taxed against nonprevailing party the reasonable costs of such proceeding, not to include attorney's fees." The DCA reasoned that the claimant was the prevailing party since the petition was received by the carrier on September 11, 2014 and the carrier then "furnished" the requested benefits on September 12, 2014, entitling the claimant to litigation costs as a matter of law. The DCA reversed the JCC order with instructions to award litigation costs.

My recommendations in light of the Jennings decision:
Prior to the PFB:

- Treat all informal requests for benefits as a PFB and act upon these requests prior to the filing of an actual petition. Yes, this places you under the gun as there is no statutory waiting period for prevailing costs per the Jennings decision. Keep opposing counsel apprised of the action to be taken, e.g., that you have contacted a physician's office to schedule an appointment.
- The E/C should communicate the name of the doctor in writing to the claimant, her attorney and defense counsel. See Lord v. Santa Rosa Corr. Inst. 135 So.3d 1170, 1171 (Fla. 1st DCA 2014); Harrell v. Citrus Cty.Sch.Bd., 25 So. 3d 675, 678 (Fla.1st DCA 2010). The Jennings Court cited these prior decisions that held medical benefits are furnished untimely where the E/C did not advise the claimant of the selection of physician. Notify your defense counsel as well.

Subsequent to the filing of a PFB:

- The E/C must determine if the claimant's attorney made a good faith effort to resolve the dispute PRIOR to the filing of the petition as required under the good faith certification requirement under 440.192(4).
- If it is determined that claimant's counsel has not made a good faith effort to resolve the dispute prior to the filing of the petition as required under the good faith certification of 440.192(4), have your defense counsel file a Motion to Dismiss and bring the matter to the Court's attention. The DCA provided us a clue in the Jennings decision by making note that the E/C did not challenge the certification that the claimant attempted to resolve the dispute in good faith prior to the filing of the petition. Please make note that the E/C must file the motion within 30 days from the date the PFB is filed; otherwise, it waives the argument. As a matter of course, analyze all petitions to ensure compliance with the specificity and filing requirements outlined in FS 440.192.
- It is recommended that the adjuster file a response to the petition within 14 days, asserting that the claimant did not make a good faith effort to resolve the issue prior to filing.
- The E/C should request that claimant bear their own costs in the proceeding. If not, certainly the E/C should contemplate filing its own motion for costs as the prevailing party under the appropriate circumstances to perhaps lessen or neutralize this situation.

Please keep in mind that prevailing party costs at the time of the filing of the petition should be quite minimal at that stage in the litigation process. However, creative and proactive claimant attorneys may attempt to use this chance to squeeze in a doctor conference or an IME and tax those costs against the E/C. This strategy will obviously depend upon the timing and how quickly the carrier responds. A much larger concern is whether claimants' attorneys will reserve on costs and agree

fees are not due in order to toll the statute under the Longley decision. See Longley v. Miami-Date County School Board, 82 So.3d 1098 (Fla. 1st DCA 2012).

In conclusion, the Jennings decision is one where the legal reasoning seems disconnected from the real world experience in claims handling and the furnishing of benefits. As the defense counsel pointed out in Jennings' oral arguments, the benefit was being provided regardless of the claimant's attorney intervention (although the evidentiary record support for this argument was not clear). I would hope that the legislature would take action to fix this situation. Until such time, please follow our recommendations to avoid exposure to costs.

Georgia's Occupational Illness & Injury Coverage Distinctions

By: Ryan Lawson, Associate, Atlanta

As we progress through the flu season, many of us will see the inevitable sickness claim come across our desks. We are then faced with the question of compensability and whether we are required to provide treatment and/or out of work benefits for a sick employee. While we find that the flu is clearly not compensable in Georgia, occupational "illness" is an interesting topic that is evaluated in a slightly different way than occupational "injury," and knowing these differences can assist you in making the correct compensability decision on a file.

In Georgia, the first question to ask is whether the disease will be evaluated as an occupational injury or an occupational disease. While this may seem to be a straightforward assessment, the Court of Appeals in Georgia has ruled that a man who inhaled noxious gasses on a single day at work prior to beginning to cough up blood suffered from an occupational injury. See Moon v. Liberty Mutual Ins. Co., 145 Ga. App. 629, 244 S.E.2d 148 (1978). Later, in the case of Canton Textile Mills, Inc. v. Lathem, 253 Ga. 102, 317 S.E.2d 189 (1984), the Court ruled that a man diagnosed with a disabling form of byssinosis (chronic narrowing of airways) after years of breathing in cotton dust suffered from an occupational *disease*. The distinction drawn by the Court of Appeals seems to indicate that diseases that form over time will be treated as "illnesses," whereas diseases that have an acute onset will be treated as "injuries."

The importance of the distinction is that it is more difficult for a claimant to prove that they suffer from an occupational illness than it is to prove that they sustained an occupational injury. In fact, from 1920 until 1946 a claimant was not even able to recover for any illness, even if the illness was clearly related to their employment, unless they could prove that the disease arose directly from an acute injury (leg amputation caused sepsis, making the sepsis compensable, etc.). The modern interpretation allows for compensation for occupational illness, but the claimant must meet the following 5 criteria: (1) A direct causal connection between the conditions under which the work is performed and the disease; (2) The disease followed as a natural incident of exposure by reason of employment; (3) The disease is not of a character to which the employee may have had substantial exposure outside the employment; (4) The disease is not of a character to which the employee may have had substantial exposure outside the employment; and (5) the disease must appear to have had its origin in a risk connected with the employment and to have flowed from the source as a natural consequence. O.C.G.A. § 34-9-280(2).

The application of this difficult to meet criteria led the Court of Appeals to reverse an award of compensation to an EMT who contracted Hepatitis B, despite his showing that EMTs are three to five times more likely to contract the disease when compared to the general population, as the EMT could not prove that the contraction of the disease was linked exclusively to any particular activity or employment. *See.* Fulton-DeKalb Hosp. Auth. v. Bishop, 185 Ga. App. 771, 365 S.E.2d 549 (1988).

The fact that the Court of Appeals reviewed this "injury" as an "illness" is also telling as to the extent of the acute onset versus chronic development prong detailed above.

Relying on the holding in Bishop, *supra*, the flu – or the common cold for that matter – would be evaluated as an "illness," which requires one to meet all five criteria listed in O.C.G.A. § 34-9-280(2). Because the flu is of a "character to which the employee may have had substantial exposure outside the employment," that is to say that the flu is easily contracted by the general population, it cannot meet the high standard for compensability and, therefore, is not compensable in Georgia.

Overall, when faced with a claim for occupational illness, the question of compensability is fact sensitive, and requires a quick investigation to reach the correct result. While it is clear that claims for benefits on account of the flu should be denied, other types of occupational illness are not always as straightforward. If you have any questions regarding the compensability of any type of injury or illness, please feel free to contact our Atlanta office to review the specific facts of your case.

Recent DCA Opinion Provides Refresher on Florida's Exposure Standards in Workers' Compensation Claims

By: Ya'Sheaka Williams, Partner, Tampa

In Festa v. Teleflex, Inc., the First DCA outlined the elements that a claimant must prove in order to recover under the exposure theory of an accident: (1) Prolonged exposure, (2) the cumulative effect of which is injury or aggravation of a pre-existing condition, and (3) being subject to a hazard greater than that to which the general public is exposed. Festa, 382 So.2d 122 (Fla. 1st DCA 1980). FS 440.02(1) provides that an injury or disease caused by exposure to a toxic substance is not an injury by accident arising out of the employment unless there is clear and convincing evidence establishing that exposure to the specific substance involved at the levels to which the employee was exposed, can cause the injury or disease sustained by the employee.

In D'Avanza for Kathryn Taylor v. Air Canada/Liberty Mutual Insurance Company, (1D15-2629) the claimant sought compensability of an alleged work place accident and asserted that she was exposed to salmonella from contaminated food served by the employer, Air Canada. Air Canada served food to celebrate its anniversary in the Tampa location. Some of the items included lox, crab-balls, and sandwiches. It was undisputed that she consumed the food. However, no one else got sick following the event. A few days after consuming the food at work, she was found unconscious in her condominium and was diagnosed with a brain hemorrhage. The claimant argued that because she suffered with a suppressed immune system and high blood pressure, the allegedly contaminated food interacted differently with her system and caused her to suffer a brain hemorrhage. She underwent brain surgery and a second surgery in which a permanent shunt was installed in her brain. She was subsequently transferred to a rehabilitation facility where she sustained a second hemorrhage and is now severely incapacitated.

The claimant filed a workers' compensation claim seeking compensability of the exposure, brain hemorrhage, and subsequent brain hemorrhage at the rehabilitation facility. The claimant asserted a temporal relationship between when she ate the food and when she became ill. Doctors testified that the claimant's exposure occurred at work based on an assumption that the Health Department opined that the claimant's exposure occurred at work. Rather, the Health Department's report only outlined potential exposure sites to include the food, her cats, or other food that she bought and consumed prior to consuming the food at work. None of these items were tested to confirm that the items may also have contained salmonella. As such, Judge Lorenzen found that a temporal relationship was not sufficient to find compensability, and denied the claim. The claimant appealed the decision and the First DCA issued an order per curium affirming Judge Lorenzen.

The claimant bears the burden to prove that exposure occurred in the workplace in order for a claim to be found compensable. Additionally, an exposure claim has a different standard of proof. Exposure must be proven by clear and convincing evidence, not major contributing cause. This is a very difficult standard for claimants to meet, so many exposure claims may be denied at the onset. When conducting an initial analysis of a claim, ensure that the correct standard is utilized when making a determination on the compensability of an exposure claim. If there is any doubt as to causation, the claim should most likely be denied. As always, please feel free to contact any of our offices during the initial investigation for a legal opinion.

Misconduct Defense Gets New Teeth in Florida

By: David Halpern, Partner, West Palm Beach

In Florida, it is understood that an employee terminated for misconduct at some point after a work-related accident is not entitled to temporary partial disability (TPD) benefits. What is less clear is, (1) What exactly constitutes misconduct and, (2) is an employee terminated for misconduct *permanently* disqualified from receiving TPD?

The recent case of Bismark Batres v Safelite and Sedgwick CMS (OJCC Case #14-012125MGK) addressed both questions. In Batres, the claimant injured his right shoulder on March 12, 2014. He submitted to a post-accident drug test, but the results were not immediately available. On May 24, 2014, the drug test results became available, and showed the claimant had tested positive for cocaine. At that point, Safelite terminated the claimant's employment and – believing that a positive drug test constituted misconduct – denied payment of TPD benefits. In so doing, it cited the company's "zero tolerance" drug use policy which had been previously explained to the claimant. In good faith, Safelite agreed to provide ongoing medical benefits. On July 24, 2014, the claimant underwent surgery on his injured shoulder.

At trial, the claimant argued that he was entitled to TPD benefits following his termination. He claimed that his drug use (which he said occurred during non-working hours) did not constitute misconduct. He also argued that even if misconduct had occurred, an employer could not use that to deny TPD benefits forever, particularly where he had undergone accident-related surgery.

In her Final Merits Order, the JCC ruled for Safelite on the TPD issue, making several important findings. First, the JCC found that a direct violation of company policy constituted misconduct. Second, the JCC found that where misconduct had occurred, it was proper for Safelite to continue its denial of TPD benefits, even where the claimant had undergone surgery. In so doing, the JCC specifically found that the claimant's surgery "did not break the causal connection" between the misconduct and the claimant's lack of entitlement to TPD benefits. It should be noted that the employer testified that a job would have been available within the claimant's post-surgical restrictions, but for the misconduct termination.

These findings were affirmed by the First District Court of Appeal in November 2015 by PCA. The lessons of Batres are twofold. First, employers should devise specific policies as to what constitutes prohibited activities, and have their employees sign a confirmation of the awareness of such policies. If those policies are later violated by an employee with an active workers' compensation claim, TPD benefits can be denied. There are ample DCA decisions that address drug and alcohol usage, even after hours, as grounds for termination when an employer has a drug-free policy that is in place, and enforced. Second, where misconduct has occurred, employers now have a strong argument that TPD benefits can be denied for the entire duration of a claim.

120 Day Update: Babahmetovic v. Scan Design's Latest Incarnation

By: Gina Case, Associate, Sarasota

On May 1, 2015, the First DCA issued an opinion in Babahmetovic v. Scan Design, 40 Fla. L. Weekly D 1030 (Fla. 1st DCA 2015) that appeared to stand for the proposition that an employer/carrier must actually elect the 120-day investigative period found in FS 440.20(4) by issuing a "120-day letter" in order to avail itself of the right to deny compensability of a claim within the prescribed time period. In the weeks following the Babahmetovic decision, case law updates and seminars equated the opinion with a new requirement that an E/C must issue a letter to the claimant electing to pay and investigate in order to rely upon the 120 day rule.

Subsequently, the E/C in Babahmetovic filed a Motion for Re-Hearing, which was granted by the First DCA. A second opinion was issued in this regard on October 8, 2015 (Babahmetovic v. Scan Design, 176 So.3d 1006 (Fla. 1st DCA 2015)) and substituted for the opinion issued on May 1, 2015. In the revised Babahmetovic opinion, the First DCA declined to address FS 440.20(4) at all, instead relying on a distinction between major contributing cause of the initial accident versus major contributing cause of a subsequent need for care when a compensable injury combines with a pre-existing condition pursuant to FS 440.09(1)(b). Thereafter, carriers questioned whether the absence of the 120-day discussion in the subsequent opinion effectively abolished the requirement of issuing a "120-day letter" to the claimant in order to elect to investigate a claim pursuant to FS 440.20(4).

To interpret the new opinion in Babahmetovic, however, as an abrogation of the requirements of FS 440.20(4) is to misunderstand the real issue before the First DCA in rendering its opinion. The issue in Babahmetovic is not whether failure to issue a "120-day letter" defeats an E/C's right to deny compensability of a claim, but whether the E/C properly denied a request for a one-time change of physician based on major contributing cause.

In the underlying case, the Employer/Carrier denied compensability of the claim based on a medical opinion from an authorized treating physician that the claimant suffered from both a sprain and pre-existing degenerative disc disease, and the sprain was less than 50% the cause of the claimant's current condition. A Notice of Denial was filed in this regard almost two (2) months following the date of accident indicating that the industrial accident is not the major contributing cause of the need for treatment. Both parties at hearing before the JCC, however, agreed that the Division filing was intended to be a statement that there was never a compensable injury. The JCC, in denying the claimant's request for a one-time change, agreed with the E/C that there was no compensable injury based on the authorized doctor's opinion that the "sprain" was less than half the cause of the injury and need for care.

The First DCA, however, opined that the JCC utilized the wrong major contributing cause analysis in finding that there was no compensable injury. The evidence presented at hearing established that the claimant did, in fact, sustain a "sprain" on the date of accident. Thus, the appropriate major contributing cause analysis was whether the need for treatment was related to the "sprain" versus the pre-existing degenerative disc disease. In essence, the First DCA found that E/C failed to present evidence that the "sprain" was caused by the degenerative disc disease and therefore not an injury that occurred within the course and scope of employment. As the only evidence presented at hearing was that the claimant sustained a "sprain" on the date of accident, the claimant established that there was a compensable injury and he was therefore entitled to a one-time change of physician. Of note, in order to reach its holding, the First DCA was not required to address the 120-day provision found in FS 440.20(4).

Based on this misunderstanding of the ultimate holding of the Babahmetovic decision, E/Cs are now questioning the current state of the 120-day pay and investigate provision. The answer, in this author's opinion, is that there simply has been no change in the requirements of FS 440.20(4). Such statutory provision provides that "Upon commencement of payment as required under subsection (2) or s. 440.192(8), the carrier shall provide written notice to the employee that it has elected to pay the claim pending further investigation…" Thus, there has always been a requirement that carriers notify claimants of their intention to invoke the 120-day pay and investigate period.

While the effect of not issuing a 120-day letter is debatable, it is important to keep in mind the purpose of the 120-day investigative period. Once an Employer/Carrier becomes aware of an alleged work related incident, it has 14 days to either deny the claim in its entirety or begin paying benefits. The 120-day provision was therefore intended to *protect* carriers from making hasty decisions regarding compensability by providing a third option ("pay and investigate"). Thus, it is within the carrier's best interests to make its intentions clear from the outset to avoid unnecessary litigation over compensability of a claim. By not issuing a 120-day letter, an E/C risks a finding that there was no election to "pay and investigate," thus equating payment of benefits with acceptance of the claim as compensable.