TOP CASES OF 2011/2012

The First District did not have a busy 2011 in the field of workers' compensation. They decided several cases that were important, but it was not the same flood as we have seen in the past. 2012 should be an interesting year.

I. ATTORNEYS' FEES:

Crawley v. Rasmussen Colling

Attorneys' fees are always an important area of litigation. So much of workers' compensation litigation is determined by whether claimants' attorneys have the ability and the incentive to litigate claims. For several years now, since the last legislative changes, claimants' attorney's fees have been governed by the fairly restrictive attorneys' fee schedule of 20/15/10 rather than by hourly fees. The legislative changes have served to keep attorneys' fees low and litigation reduced.

Although there is not a major case to discuss from the First District on attorneys' fees, there certain is one at the JCC level. A case from a JCC is a bigger deal now than it would have been ten years ago. All of the JCCs are electronically networked and with DOAH becoming so sophisticated now, it is easy for one JCC in Pensacola to know what another JCC in Miami is saying in his orders.

The case of Crawley v. Rasmussen Colling will be such a case. Rasmussen was heard in Jacksonville by Judge Neal Pitts. It finds that the claimant's attorney is entitled to the sanction of an attorney's fee against the

employer and carrier, not under Section 440.34, but rather under Section 57.105(1)(a). This is a big deal.

The judges' entire decision was an analysis of whether Section 57.105(1) applies to workers' compensation matters. That is a very controversial thought because all attorneys' fees except for appeals and a rule nisi have always been governed under Section 440.34. Section 57.105 is commonly known as a situation where a party files a frivolous claim or there is a frivolous defense involved. That is not actually accurate. Section 57.105, Florida Statutes, provides that "the court" shall award a reasonable attorney's fee on any claim or defense at any time "during a civil procedure or action' in which "the court" finds that the losing party or the losing parties' attorney knew or should have known that a claim or defense when initially presented to the court or at any time prior to trial was not supported by the material facts necessary to establish the claim or defense. Section 57.105(6), Florida Statutes, further provides for sanctions or remedies available under law or under court rules.

There are no reported decisions applying Section 57.105 at the trial level where a JCC is involved. Judge Pitts notes that the First District Court of Appeal has applied 57.105 to appeals in workers' compensation matters. To apply 57.105, he analyzes the Section and decides ultimately that a claim (PFB) brought under Chapter 440 is a "action" and that the JCC is a "court". In order to make that jump, he relies upon the prior claim of Demedrano v. Labor Finders, 8 So.3d 498 (Fla. 1st DCA 2009) which held that costs associated with paralegal services were not costs which the claimant's attorney could be reimbursed by the

claimant out of a settlement, but also held that Section 57.104 is mandatory when attorneys' fees are awarded in a settlement.

Critically, Judge Pitts ruled that Section 57.104, which applies to workers' compensation cases is no different from 57.105 because the language of the two statutory sections are so similar. The result of that holding is that since 57.105 allows for the sanction of an attorney's fee and since Section 57.104 already applies to workers' compensation, then Section 57.105 applies as well.

The next issue is just as important. Judge Pitts states that 57.105 does not require that the claim was frivolous or the defenses frivolous, rather the parties can recover attorney's fees for any claim or defense that is insufficiently supported!! The test under 57.105 is simply whether the party or his lawyer knew or should have known, at the time of the filing or later when the parties discover or should have discovered that a claim or defense lacks factual or legal merit. It is enough that the parties seeking fees is able to establish that the claim or defense is insufficiently supported. That is a very low standard and one that occurs in many, many cases.

For example, in this case, all they were fighting about was whether the claimant could have a return appointment with a doctor for treatment of his right knee and authorization of an orthopaedic surgeon for an evaluation of the claimant's hips and back. The employer and carrier defended the case on lack of causality on the back. Depositions were taken and it is probable that the employer and carrier should have determined that they were going to lose and retreated from the defenses. There were conflicting medical opinions but mostly

the evidence was on the claimant's side. The defense was certainly not frivolous but it was fairly easy to determine that the defense lacked a factual or legal merit. That is a very low standard for determining attorneys' fees.

If that was not complicated enough, let me complicate it more. I don't think attorneys' fees payable under 57.105 automatically need to be paid by the 20/15/10 schedule. In other words, the claimants' bar will certainly contend that hourly fees are appropriate under 57.105.

II. PENALTIES:

Perry v. Ecolab, 37 Fla. L. Weekly D147

This case tries to reconcile two statutory sections which seem to be in conflict. Section 440.20(7) controls the payment of penalties and requires that a 20% penalty be paid if compensation is not paid within seven days after it becomes due. Benefits are due on the date the order is entered ever since Rutherford v. Seven Up Bottling Company, 83 So.2d 269 was decided in 1955.

The complicating factor is that an order is not final until 30 days after it has been mailed to the parties unless a timely appeal is filed. That is Section 440.25(4), Florida Statutes.

Here is the controversy. The judge enters an order on January 1st. Seven days later, that order is supposed to be paid. But, if you take an appeal within 30 days after the order is entered, the order never becomes final and you don't have to pay it. The "Catch 22" though is that if you were thinking about taking an appeal and don't pay the order within seven days and then decide not to take the

appeal, penalties are due because you have waited more than seven days to pay the order.

The case of Perry v. Ecolab, 37 FLW D147 holds is that if the carrier doesn't pay within seven days and then doesn't appeal, they owe penalties and eventually costs and attorneys' fees.

III. APPORTIONMENT – A REVIEW OF STAFFMARK V. MERRILL, 43 So.3d 792 and NEWICK v. WEBSTER TRAINING, January 30, 2012 First District Court of Appeal

Staffmark v. Merrell, 43 So.3d 792 (Fla. 1st DCA 2010)

Apportionment is one of the most difficult and confusing areas of the workers' compensation law. Here are the facts of Staffmark.

On November 7, 2008, the claimant injured his low back. The carrier accepted at first and then denied the claim as unrelated. The claimant had several prior back injuries, some workplace related and others not. The claimant had only worked for the employer three or four months in a pain free fashion prior to the accident.

The EMA doctor testified that the 2008 accident was a permanent aggravation of the pre-existing condition and that the 2008 accident was the major contributing cause of the claimant's disability and need for treatment. He said that 40% of the claimant's disability and the need for treatment pre-existed the accident and that 60% was as a result of the accident. He also said that 75% of the need for surgery was from the accident.

The judge of compensation claims accepted the claimant's position and denied apportionment. On appeal, the employer/carrier contended that apportionment was proper. The claimant contended that apportionment applied only after maximum medical improvement was reached.

The First DCA reminded us that prior to 2003, there was no apportionment of temporary or medical benefits. However, after the change in 2003, 440.15(5)(b) allows for apportionment for all indemnity benefits before and after maximum medical improvement and all medical benefits before and after maximum medical improvement.

Here is the law:

1. For temporary benefits: Only disability associated with the compensable injury should be payable, excluding the degree of disability existing at the time of the accident;
2. For medical benefits: The employer/carrier can apportion the percentage of the need for such care attributable to the pre-existing condition;
3. Permanent indemnity: For apportionment, the employer/carrier needs evidence of a permanent impairment or disability attributable to the accident or injury and an anatomical impairment rating attributable to the pre-existing condition.

If you are trying to apportion temporary total or temporary partial or medical, you do not need to have an impairment rating for a pre-existing

condition. The claimant does not need to have reached maximum medical improvement.

If you are apportioning permanent indemnity benefits, you need a rating for your accident and a rating for the pre-existing accident.

MOST IMPORTANT:

The Court concluded with the discussion that says that you can only apportion a pre-existing injury or condition that is unrelated to an employment accident. In other words, you cannot apportion a pre-existing workers' compensation accident. The theory behind that is that in a pre-existing employment related accident, the carrier has a Section 440.42 contribution claim and the claimant has another potential claim against another employer and carrier.

So where are we now?

1. You are allowed to apportion temporary total, temporary partial, medical, impairment and permanent total disability;
2. You can only apportion pre-existing injuries or conditions <u>unrelated</u> to an employment accident. But what if a pre-existing workers' compensation accident is settled or where the Statute of Limitations on the prior accident has run? There is no contribution or potential of a new claim.
3. The standards for medical or a temporary benefit apportionment do not require a permanent impairment rating.

For temporary disability you would ask: Doctor, of the whole, what percent of disability existed right before the accident? (This would exclude any pre-existing condition and even what is called the merger effect leaving only the disability from the accident as the employer/carrier's responsibility.)

For medical apportionment, you would ask: Doctor, what percent of the need for treatment is attributable to the accident? (This would exclude pre-existing and any merger effect.)

For permanent benefits, you would need a rating. What if there was no rating for a pre-existing accident because it wasn't a workers' compensation case. Can the doctor from the workers' compensation case actually assign a permanent impairment rating from the pre-existing conditions?

And finally, what in the world do you do about apportioning permanent total disability?

Newick v. Wesbter Training January 30, 2012, First DCA 2012

Then, the case of Newick came out on January 30, 2012. In Newick, the First District decided that the employer and carrier were allowed to apportion the claimant's pre-existing condition even though it resulted from an industrial accident because the resulting injury was deemed not to be compensable.

The First District Court of Appeal has drawn an exception to the Staffmark line of cases. The exception is that they will grant apportionment, even for a pre-existing industrial accident, when the pre-existing industrial accident is deemed not compensable.

Where does that leave us? Clearly, we can apportion pre-existing non-industrial accidents. Now, we can apportion a pre-existing industrial accident that was deemed not to be compensable. In Newick, the claimant chose not to file claims on the pre-existing industrial accidents. What would happen if the claim went to trial on an accident and lost it on compensability? I don't think it is a stretch to believe the carrier would be able to apportion that accident as well simply citing Newick.

Then, what happens if the Statute of Limitations has run on accident #1 and therefore the carrier under accident #2 could not seek contribution under Section 440.42. I don't think it is a big step to go from Staffmark to Newick when apportioning that last fact pattern.

IV. PERMANENT TOTAL DISABILITY:

Diocese of St. Petersburg V. Cayer, 37 Fla. L. Weekly D60

This is not an important case for its facts but it does reiterate exactly what a claimant has to prove in order to get permanent total disability. That is why we will discuss it. It refers back to Blake v. Merck, 43 So.3d 882 (Fla. 1st DCA 2010).

In order for a claimant to prove permanent total disability when he does not have a listed injury (statutory permanent total), the claimant must present evidence of

1. permanent medical incapacity to engage in at least sedentary employment, within a 50 mile radius of the employee's residence, due to physical limitations; or

2. permanent work related physical restrictions coupled with an exhaustive but unsuccessful job search; or

3. permanent work-related physical restrictions that, while not alone totally disabling, preclude the claimant from engaging in at least sedentary employment when combined with vocational factors.

It is easy to analyze what #1 and #2 mean. In #1, the doctor has to testify that the claimant is medically incapacitated when engaged in sedentary employment within a 50 mile radius of his residence due to physical limitations. In other words, there is a medical standard with the doctor testifying to medical incapacity and physical restrictions. Number 2 is medically based as well. The doctor has to testify to physical restrictions and that has to be coupled with an exhaustive but unsuccessful job search. To sum up, #1 and #2 are medically based.

Number 3 is the wild card. The claimant has to show permanent work related physical restrictions, but they do not have to be totally disabiling. Even though they don't have to be totally disabiling, they preclude the claimant from engaging in at least sedentary employment when combined with vocational factors. In other words, the vocational expert testifies that because of the claimant's physical restrictions, he is not employable from a vocational standpoint. That is not a very high standard and you must be prepared with your own vocational expert in every single case where there is a potential for permanent total disability.

Gilinski v. Pan American Bank, 36 Fla. L. Weekly D2709 (Fla. 1st DCA 2011)

This case deals with the suspension of permanent total disability when the employer and carrier provide the claimant with an Earnings Report Form DWC-19 to complete and return within 21 days pursuant to Section 440.15(1)(e)2.b, Florida Statutes.

The claimant has 21 days to return the form. In this case, the claimant didn't return it in 21 days. When he did return it, it didn't have the proper social security information in it. The claimant finally returned the filled out earnings report way outside the 21 day period. When the claimant submitted the completed earnings report, the employer and carrier resumed permanent and total disability payments, but did not pay the gap period from the time the claimant did not submit the report until the time the claimant did submit the report. The trial judge ruled against the claimant finding that the employer and carrier did not owe the gap period because the claimant willfully failed to complete the earnings report and the employer and carrier properly suspended disability payments as a consequence.

The appellate court ruled that Section 440.15(1)(e)2.b, Florida Statutes and the Florida Administrative Code required the claimant to turn a completed earnings report within 21 days after receipt of that report from the employer/carrier. The Statute also holds that the employer and carrier should not be required to make any payment of benefits for permanent total disability for any time period which the employee willfully fails or refuses to report upon request by the employer/carrier.

The First District held that the employer/carrier did not have to pay the benefits because the claimant willfully failed or refused to timely submit the report and further ruled that there did not have to be a court order allowing the employer and carrier to suspend the benefits. They could do so administratively.

V. TEMPORARY PARTIAL DISABILITY

Perdue v. Sebring Marine, 50 So.3d 1140 (Fla. 1st DCA 2011)

The District Court of Appeal held that because the employer/carrier sought to avoid payment of the requested temporary partial disability benefits on the grounds that the DWC-19 Employee Earnings Report Forms had not been completed, the employer/carrier had the burden to prove that it sent the forms to the claimant.

Republic Waste Services. V. Ricardo, 68 So.3d 934 (Fla. 1st DCA 2011)

The current administrative rule requires the claim handling entity to send any injured employee who has been released to return to work on a restricted basis a letter along with a DWC-19 Form explaining the employee's eligibility for temporary partial disability benefits. This letter to the injured employee must include notice that temporary partial disability benefits may cease if the injured employee does not return the form as requested.

VI. MEDICAL: ONE TIME CHANGE

This year, the big medical controversy deals with the provision for a one time change. Section 440.13(2)(f), Florida Statutes, provides as follows:

> Upon the written request of the employee, the carrier shall give the employee the opportunity for one change of physician during the course of treatment for any one accident. Upon the granting of a change of physician, the originally authorized physician in the same specialty as the change physician shall become deauthorized upon written notification by the employer or carrier. The carrier shall authorize an alternative physician who shall not be professionally affiliated with the previous physician within five days after receipt of the request. If the carrier fails to provide a change of physician as requested by the employee, the employee may select the physician and such physician shall be considered authorized if the treatment being provided is compensable and medically necessary.

I don't know how one paragraph has so many issues in it. There are timelines issues. There are issues of writing to the deauthorized doctor. There are issues about whether the doctor is professionally affiliated with another doctor. Most of all, there is a controversy about when the claimant asks for a one time change does it has to be to another doctor in the same specialty.

There is no appellate court case yet on this, although I assume one will be decided shortly. I have found two important cases decided by the judges of compensation claims. One is called Weathersbee v. Palm Beach County (decided by Judge Punancy on September 12, 2011) and the other is called

Gunsby v. Southeast Personnel Leasing, (decided by Judge Hill on May 27, 2011). Judge Punancy's is the more elaborately written. She notes that she finds no requirement in Section 440.13(2)(f), Florida Statutes, that the employee's right to a one time change of physicians has any limitation of specialty. In other words, the Statute does not state any limitation as to the specialty area of medicine the claimant may request for a one time change. The Statute gives the employer/carrier the right to deauthorize the originally authorized treating physician in the same specialty as the change physician, but it does not say that the two physicians have to be in the same specialty.

The case sums up by saying that the statute does not negate the "claimant's absolute right in the first instance to select a specific type of physician (be it a specialist or not) for the one time change".

Judge Hill found exactly the opposite in the Gunsby case. The claimant wanted a change of physician from an orthopaedist to a pain medicine specialist. The orthopaedist testified that if the claimant needed a pain medicine specialist, he (the orthopaedist) would refer him to one. When the claimant asked to see a different specialty, the employer and carrier would only authorize a different doctor in the original specialty.

The trial judge concentrated on the fact that both times that the claimant requested a one time change that the carrier authorized a doctor immediately and that therefore, the employer and carrier retained control over the selection of the physician to whom the claimant's care would be transferred. It did not

concentrate on the claimant's allegation that he wanted a different specialty, only that the offer from the employer and carrier was timely.

Where are we now? The Statute is written very restrictively and the part in it about deauthorizing the doctor in the same specialty is fairly compelling. Personally, I have never quite appreciated how a one time change could be restricted to the same specialty. For example, if the claimant needed surgery, why would he have to be seen by another primary care physician rather than a specialist? In any event, we are going to have this decided for us sometime in the year 2012.

VII. COMPENSABLE ACCIDENTS:

Sentry Insurance Company v. Hamlin, 69 So.3d 1065 (Fla. 1st DCA 2011)

This is the best compensability case in years because it has absolutely every arising out of question involved. Wait until you hear these facts. This could only happen in a workers' compensation case.

The claimant is injured on the premises of the employer. He was injured in the employees' parking lot where he was allowed to go. His deviation was short term and he was allowed to go to the parking lot on breaks. The wrinkle in this case is that while the employee was working at his cubicle, his supervisor tells him that a tow truck was near his vehicle in the parking lot. The claimant runs to the parking lot and has a conversation with the tow truck driver who tells the claimant that he (the driver) has been ordered to take possession of his car and suggests that the claimant call the bank. The claimant calls the bank and

the bank tells him that the car is being repossessed because he did not make his payments. The bank tells the claimant to get his personal belongings (nothing work related) out of the car. While the claimant is getting his personal belongings out of the car, the tow truck driver starts to drive off dragging the claimant eventually causing him injuries. The entire episode only took 15 minutes. The claimant is permitted two 15 minute breaks per day and had not taken his break yet. The parking lot is exclusively for employees of the employer and is monitored by security guards. The claimant was not disciplined or sanctioned in any way for going to the parking lot in response to repossession of his car. I told you these facts were wonderful.

The claimant argued that the case was compensable under four separate arising out of theories. The first is that the accident happened on the employer's premises. The second is that the injury occurred during a paid break. The third is that the accident was compensable under the personal comfort doctrine, and even if it was a deviation, it was an insubstantial deviation. For the fourth, the claimant argued that it was compensable because his retrieval of his school books was an emergency and injuries sustained as a result of an emergency designed to save property are compensable under Section 440.092(3), Florida Statutes.

For an injury to arise out of work performed, the injury must be:

1. Causally connected to the claimant's employment; or
2. Have had its origin in some risk incident to or connected with the employment; or

3. Flow from the employment as a natural consequence.

The claimant's first two arguments (premises and paid work break) are inappropriate because the claimant has not shown any work connectedness. Under the premises rule, the claimant must be engaged in some type of activity related to work, such as getting tools, entering the work place or picking up a pay check. As far as the paid break is concerned, the question is usually resolved in favor of the claimant because there has been no substantial deviation from work. In other words, the break is of such a short duration and related to personal comfort, so it is essentially a continuation of work. But, injuries suffered on the premises or during paid breaks are not compensable if the risk given rise to injury is distinctly or wholly personal in nature and the injury results from the risk that the employee has <u>imported</u> into the workplace.

The First District gives examples such as an at work altercation which involved a co-worker with whom a claimant had been romantically involved. Although the relationship had apparently ceased and the two had not spoken for a month, upon arriving at work the day of the altercation, the claimant suffered a knife wound inflicted by the spurned lover regarding the termination of the relationship. Compensability was denied because there had to be some contributing factor from employment before coverage could be found.

Frequently, the court has found situations compensable when an implement of employment of a fixture of the workplace was used in an injury. In one case, the court found compensability when workplace gossip resulted in an injury to the claimant but the injury was made using a workplace tool.

The claimant's next argument involved the personal comfort doctrine. The personal comfort doctrine applies when either there is a work related personal comfort or there is a neutral risk. Every personal comfort case accepted as compensable has to meet three prongs:

1. The activity has been a traditional or routine part of the workplace experience (it is incidental to work); and
2. The employee's participation in an activity of this type has held to benefit the employer by producing a refreshed employee; and
3. The injury results from either a work created risk or a neutral risk.

A claimant who fails to meet all three prongs does not qualify for compensability under the personal comfort doctrine. Traditional acts of personal comfort are such as eating a snack, smoking or taking a restroom break. These are incidental to work. In this claimant's accident, he was hanging out of a vehicle window while his lender repossessed his car. Recovering property from a repossessed vehicle is not the type of activity normally associated with creating a "refreshed" employee. The claimant himself cannot declare any activity as simply being personal comfort. It has to meet the three prong standard. It certainly has to be something for the benefit of the employer or at least a neutral activity. It cannot be completely personal in nature.

The claimant's last argument was that his injury was compensable because an emergency triggered his accident which was designed to save life or property. The court defined emergency "as an unforeseen combination of circumstances the resulting state that calls for immediate action or urgent need

for assistance". There are cases that have held similar emergencies compensable when the claimant acted to recover property that was being stolen from his employer's premises. The court holds that before any accident can be held to be "in response to an emergency" the emergency must arise in a situation that would be objectively recognized by others as an emergency requiring similar action to be undertaken by the claimant. The law does not permit the claimant to bring acts within the scope of this section by declaring a personal emergency.