Profound Cases From the First District Court of Appeal

The First District Court of Appeal had a busy last six months of 2010 deciding way more important cases than in the first six months of 2010. 2011 has gotten off to a slow start, but there are still some important cases that were decided and certainly 2011 will be a big year for attorneys' fee decisions.

1. ATTORNEYS' FEES

Kauffman v. Community Inclusion, Fla. 1st DCA – (March 23, 2011)

The big attorney's fee case of 2011 was and will be Kauffman v. Community Inclusion. It was orally argued before the First District and decided on 3/23/11. It can best be described as the second coming of Emma Murray.

A little bit of history is in order. Murray v. Mariner Health, 994 So.2d 1051 (Florida 2008) was decided on October 23, 2008. In that case, the Florida Supreme Court ruled that the word "reasonable" in 440.34 – the attorneys' fee section - means that the judge of compensation claims had discretion regarding the award of fees and could award a "reasonable" fee based upon the number of hours that a claimants' lawyer spent in securing the benefits, rather than simply following the statutory formula of 20/15/10.

Following the Murray decision, the 2009 Florida Legislature changed the law in 440.34(1) and (3) and took out the word "reasonable" that allowed the Emma Murray interpretation. It was fairly clear after the legislative session that the only attorney's fee to be awarded when the claimant's attorney successfully prosecutes the claim on behalf of the claimant was a statutory fee.

The case of Kauffman v. Community Inclusions is the new test case of the revised Statute. There are several similarities between Emma Murray and Jennifer Kauffman. First, one of the claimants' attorneys in both was Brian Sutter. He is an extremely competent and smart claimants' lawyer. The amount in controversy is remarkably close in both cases. In Emma Murray, it was $3,200 and in Jennifer Kauffman it is $3,400. The hourly rate if the statutory guidelines were followed in Emma Murray would be $8.00 an hour. The hourly rate if the statutory guidelines were followed in the Kauffman case would be $6.84 per hour. You can really see how this case is being properly set-up.

In a nut shell, Kauffman claimed that she was injured in an accident on July 23, 2009. The carrier denied compensability of the accident. The case went to trial and the claimant won compensability, temporary total disability benefits and medical treatment for her back. That was all that was involved.

The judge of compensation claims awarded a statutory attorneys' fee of $648.41 on the $3,417.00 worth of benefits which amounted to $6.84 an hour. The claimant appealed and oral argument has been had in front of the First District Court of Appeal. The Order came out on March 23, 2011.

The Order affirmed the statutory attorney's fee of $684.41 for securing $3,417.03 in benefits. The First DCA rejected the claimant's arguments that the statute was unconstitutional and they rejected a technical argument that there is a difference between an awarded fee and an approved fee.

Basically what the First DCA has done is punt the ball to the Supreme Court who will have the opportunity to decide this case later in the year. This

time the Supreme Court will not have the partial fix of the word “reasonable: available to it. They will actually have to decide whether the fee statute is constitutional.

Carrillo v. Case Engineering, Inc., 36 Fla. L. Weekly D339

In this case, the employer and carrier paid the claim but later decided that the claimant’s benefits should be denied on the basis of the fraud defense. The claimant went to trial and won and the question was whether the claimant’s attorney was entitled to a fee on the basis of compensability or whether the claimants’ attorney was entitled to a fee for only the actual benefits secured. The First District Court of Appeal indicated that when a carrier denies a claim on the basis of fraud, what they are saying is that the claimant is not entitled to any further indemnity or medical benefits. As such, if you deny a claim on the basis of fraud, the claimant’s attorney is entitled to a fee on any benefits that follow thereafter. They did not address whether the fee would be hourly or statutory. Although it is presumptively statutory, stay tuned.

2. PREVAILING PARTY COSTS

One significant weapon in defending cases is the assessment of prevailing party costs. Historically, costs were only awarded to the claimant when the claimant successfully prosecuted his claim against the employer/carrier. Costs were not assessed against the claimant when the employer and carrier won. That all changed on October 1, 2003 when the prevailing cost provision was added to 440.34(3). In the last few years, there have been cases that have been decided that have been very favorable to the employer and carrier about when costs were awardable to the employer and carrier from the claimant. They dealt with such things as voluntary dismissals by the claimants' lawyer and certainly dealt with issues if the claimant lost at trial.

This year, we have Sandvik Incorporated v. Decoursey, 31 So.3d 931 (Fla. 1st DCA 2010). In that case, the claimant's won several months of temporary partial but was denied five days of temporary partial because the claimant voluntarily limited his income during that time. The carrier claimed that it prevailed on its defense concerning those five days and that it was entitled to prevailing party costs. The court found that the employer/carrier's affirmative defense was that the claimant voluntarily limited his income during the entire time claimed and thus denied prevailing party costs because the employer and carrier failed to meet its burden.

Although this case does not address the really important question of whether the employer and carrier have to win all of the issues to claim prevailing party costs, it certainly stands for the proposition that if the employer and carrier

lose most of the issues but win a little bit that they are not entitled to prevailing party costs.

Hernandez v. Manatee County Government, 50 So.3d 57 (Fla. 1st DCA 2010) is also a prevailing party case which I think is kind of technical. The judge of compensation claims awarded costs to the employer and carrier for depositions taken prior to the filing of the Petition for Benefits which resulted in the Order. The claimant took the position that since the depositions were taken prior to the filing of the last Petition for Benefits, that those costs would not be taxed against the claimant. The First District said the standard was whether the depositions were received into evidence at the later proceeding and relevant to any issue. As such, even though the depositions were taken before the Petition for Benefits that resulted in the ultimate order, costs could be accessed.

Lastly, there is the case of Carrillo v. Case Engineering, Inc., 36 Fla. L. Weekly D339, which we talked about on attorneys' fees but which is also relevant to prevailing costs. It holds that the prevailing cost statute is not retroactive. If the accident happened before October 1, 2003, prevailing costs are not awarded.

3. Statute of Limitations

Gore v. Lee County School Board, 43 So.3d 846 (Fla. 1st DCA 2010)

The claimant had a metal prosthesis inserted during a partial knee replacement. The doctor advised that the surgery would last for seven to ten years and that the device would wear out over time. The claimant did not see the doctor for six years and when the claimant wanted to see the doctor, the employer/carrier denied on the basis of the Statute of Limitations.

In 1993, the Legislature removed either inadvertently or not the Statute of Limitations provision that indicated that there was no Statute of Limitations at all for a prosthetic device. The carrier in this case argued that since the language was removed in 1993, that there is no reason that the Statute of Limitations would not run on a prosthetic device.

The Court held that the Statute of Limitations had not run in this case. They said that as long as the claimant can establish that the employer/carrier had actual knowledge of the continued use of the medical apparatus (which is what they called this prosthetic device), the Statute of Limitations is tolled. They said that that this case was similar to those cases that dealt with TENS units, back braces, pacemakers, prosthetic limbs and medical apparatus for medical care if the employer/carrier had knowledge. The bottom line is that if the employer/carrier knows about the use of the apparatus, the Statute of Limitations is tolled. Frankly, I don't view this case as anywhere near as big a deal as one that deal with back braces and TENS units. In those instances, the employer/carrier really have no reason to know whether the claimant is using

them nor not. A piece of metal that is in the claimant's knee is way more obvious. But does this case mean that if any metal is inserted in surgery, the Statute of Limitations never runs.

4. Independent Medical Evaluations

Lehoullier v. Gevity/Fire Equipment Services, 43 So.3rd 834 (Fla. 1st DCA 2010)

This is a case which educates us on the definition of "dispute" which is a necessary ingredient in order to obtain an independent medical evaluation.

The claimant had a compensable accident and sees selected authorized doctors. The claimant then filed multiple Petitions for Benefits some for psychological problems and some for indemnity benefits. The parties go to mediation and resolve all the claims. The carrier agrees to authorize a psychiatrist of its choice. An Order is entered dismissing all Petitions for Benefits. **That is the key to the case.**

Then the carrier files a Motion to Compel the claimant's attendance at a neuropsychiatric IME. The carrier expressed concern over the existence of a psychiatric condition and with the longevity of the claimant's care with one of the authorized physicians. The claimant responded that the judge of compensation claims could not force the claimant to attend an independent medical evaluation because no "dispute" existed within the meaning of 440.13(5)(a), Florida Statutes. The judge of compensation claims ruled for the employer/carrier and the claimant appealed. The First District Court of Appeal stated that 440.13(5)(a) permits an independent medical evaluation if there is a "dispute" concerning overutilization, medical benefits, compensability or disability.

In this case, there was not a dispute because the claimant had not requested any benefit or medical treatment that the employer/carrier had

declined to provide. Simply expressing concern over the claimant's lack of progress with the physician is not a dispute. To create a dispute, the employer and carrier are required to deny medical benefits.

A second statutory section, 440.13(2)(d) provides that the carrier has the right to transfer care if an independent medical evaluation determines that the claimant is not making appropriate progress in recuperation. Section 440.13(2)(d) does not give the carrier a right to an independent medical evaluation. Rather, Section 440.13(2)(d) presumes the existence of a "dispute warranting an initial apportionment of an independent medical evaluation as required by Section 440.13(5)(a).

Section 440.13(2)(d) applies only after the dispute pursuant to Section 440.13(5)(a) and the independent medical evaluation takes place. This is why the Court's logic is faulty. They analyze workers' compensation as if it were not an ongoing case where most of the time there is no actual litigation. The carrier has to deny a benefit to create a dispute in order to get an independent medical evaluation. If the carrier reasonably believes that the claimant isn't making appropriate progress but there is no legal dispute, what can the carrier do?

Gomer v. Ridenhour Concrete, 42 So. 3d 855 (Fla. 1st DCA 2010)

The issue in Gomar is how many independent medical evaluations does the claimant get?

The claimant filed prior Petitions for Benefits which the carrier denied. The claimant underwent an independent medical evaluation with a doctor after which the employer/carrier accepted the claim and paid benefits.

After a while, the treating doctor put the claimant at maximum medical improvement with a 0% rating. The claimant got his one time change doctor. That doctor put the claimant at maximum medical improvement with a 0% rating as well. The claimant returned to his original doctor for an updated IME.

At the final hearing, the judge of compensation claims excluded the updated IME because 440.13(5)(a) limits parties to one IME per accident. The First DCA says that the Statute provides the one IME per accident and not one IME per specialty. Here is the critical holding: the Court held that one IME per accident does not prevent the same examiner from seeing the claimant for an updated IME where there is a new "dispute".

What if the original IME doctor retires or dies? What if the new "dispute" has absolutely nothing to do with the specialty of the original IME doctor? Can the claimant return for 10 or 12 updated IME's?

5. Temporary Partial Disability

Wyeth/Pharma Field Sales v. Toscano, 40 So.3d 795 (Fla. 1st DCA 2010)

The claimant had a high wage earning job with a lot of walking, lifting, pushing and pulling before the accident. She injured multiple body parts in a compensable accident.

During the claimant's recovery, she was restricted by her position from performing the functions of her pre-existing job. She was cleared for sedentary and later for part-time sedentary work. Importantly, the employer did not offer her a modified job within her restrictions or help to find her employment. The employer then laid her off along with 1200 other employees.

The claimant claimed temporary partial disability benefits with post-accident wages of 0. The employer/carrier contended that her loss of earnings was not causally related to her workplace injuries but rather to corporate downsizing. The employer/carrier further contended that she was capable of working and voluntarily limited her income.

Basically, at the hearing, the employer/carrier introduced no evidence suggesting that the claimant had refused suitable gainful employment offered to her. The employer/carrier introduced no evidence that the claimant was discharged for misconduct or left employment for unjustifiable reasons. Instead, the employer/carrier argued that the claimant could not meet her burden of proof by proving a causal relationship between the injury and the subsequent loss of income because she failed to do a job search.

The trial court ruled for the claimant and the carrier appealed. Here are the rulings of the First District Court of Appeal.

1. The claimant has the burden of proof to show only a causal connection between the injury and the loss of income. Basically, this is whether the physical limitations from the accident contribute to the claimant's resulting loss and reduction in wages below 80% of the pre-injury wages. Another way of putting this is that it is the economic disruption caused by the injuries.
2. There is a big difference between temporary partial disability and permanent total disability. In permanent total disability, the claimant has to show that he can't do all forms of employment. The claimant's burden is far less to show temporary partial disability.
3. Holding #3 is that after the claimant meets the burden of proof, the burden shifts to the employer/carrier to show:
    a. deemed earnings;
    b. voluntary limitation of income;
    c. misconduct;
    d. leaving for unjustifiable reasons;
    e. the claimant refused work;
    f. the claimant refused suitable modified employment.

In this case, the employer/carrier didn't even offer evidence as to any of the defenses. The position of the employer/carrier that the claimant did not meet its burden of proof because of the 1200 person layoff was denied because that

fact is irrelevant to the claimant meeting her burden. The court said that the layoff is not a defense.

Then, the First DCA directly attacked the issue of the lack of a job search. The court said that job search is not in the statute for accidents after January 1, 1994. It is no longer the employee's obligation or a defense for the employer and carrier to show lack of job search. Lack of job search does not mean lack of causation.

The claimant can do a job search and this might help her, but the lack of a job search is not reason to deny the claim. Speaking editorially, the carrier did not do a good job in this case. They said that since the claimant did not do a job search, they didn't have to put on any evidence. They said that since there was a 1200 person layoff, they did not have to put on any evidence. The best defense is to take the claimant back to work or to show one of the other affirmative defenses.

Williams v. Western Contractors, 43 So.3d 780 (Fla. 1st DCA 2010)

This case allowed temporary partial disability benefits without the claimant conducting a job search.

Alie v. Crum Staffing, Inc., 41 So. 3d 1007 (Fla. 1st DCA 2010)

Another no job search required case.

6. Permanent Total Disability

Blake v. Merck, 43 So.3d 882 (Fla. 1st DCA 2010)

The employer/carrier's vocational expert presented job openings to the claimant. There was no evidence that the claimant was ever offered or refused a job. The claimant must prove:

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

Hernandez v. Paris Industrial Medicine, 39 So.3d 466 (Fla. 1st DCA 2010)

The claimant filed for permanent total disability. The employer/carrier obtained a vocational assessment of its own choosing. That provider pretty much said the claimant was permanently and totally disabled. The claimant obtained a vocational expert who said the claimant was unemployable.

Less than 30 days before the trial, the employer/carrier wanted to delete its vocational expert and replace him with a new one. The JCC allowed this and struck the deposition of the employer/carrier's first vocational expert and said that each side gets one expert.

The JCC accepted the employer/carrier's second provider and said that the claimant was not permanently and totally disabled.

The First District Court of Appeal ruled that the first vocational expert's evidence was admissible. As for the employer/carrier's contention that since there is only one IME per accident, there is only one vocational expert per accident, the First District rejected this. They said there is no statutory section regarding vocational experts that limits the choice to one per accident.

7. Advances

Lopez v. Allied Aerofoam, 48 So.3d 888 (Fla. 1st DCA 2010)

The issue of advances has been around a long time. Back in the 1980s, claimants contended that when they were entitled to permanent total disability, that the judge could award the present value of permanent total disability benefits in a lump sum advance. That became a big deal and there were dozens if not hundreds of cases litigated on that basis. The statute changed to make it a lot harder. This case deals with small advances. They are advances under 440.20(12) where the advance sought is $2,000 or less.

The case says something rather astounding. The wording of the statute does not require proof that the injured worker will actually get benefits in the future to repay the advance or that the case is even actually compensable. The statute requires that the Court take into consideration the interest of the person seeking the advance, but does not say anything about prejudice against the employer/carrier. Basically, the judge of compensation claims can order an advance if he finds that the advance is in the best interest of the claimant, where the claimant: (1) has not returned to the same or equivalent employment with no substantial reduction in wages or (2) has suffered a substantial loss of earning capacity or (3) has a physical impairment, actual or apparent.

This case set off an avalanche of claimants wanting small advances. Basically, they wanted a $2,000 to finance the litigation in their case. Since the First District had held that the claimant doesn't even have to show compensability or that there will be benefits from which to repay the advance, the

claimants' bar is taking the position that all advances $2,000 or under would be pretty much automatic.

Martinez v. Delta Star Electric, OJCC #10-004535NPP (January 20, 2011)

This is a case that our firm defended on an advance. The hearing on the Motion for Advance occurred after the final hearing but before the Order was issued. The claimant's Motion for Advance sought the advance only on the basis of the claimant's substantial loss of earning capacity.

The employer/carrier argued that there was no loss of earning capacity because the claimant worked for the employer for over a full year without restrictions at the same rate of pay following the accident and then was laid off from the employer due to economic reasons. Subsequently, the claimant worked for three employers doing the exact same type of work that he did for the employer in the case and he earned similar wages with those three employers.

The judge of compensation claims denied the motion for advance because the claimant did not prove a loss of wage earning capacity.

City of Miami v. Mazur, 449 So.2d 986 (Fla. 1st DCA 1984)

This older case stands for the proposition that the claimants' attorney cannot seek fees for securing an advance because the advance simply determines the method of payment not whether payment is due.

8. Penalties

Interstate Brands v. Blanco, 50 So.3d 665 (Fla. 1st DCA 2010)

The employer and carrier paid permanent total disability and permanent total disability supplemental benefits from 1999 until January 10, 2008 when benefits stopped without explanation. The claimant's attorney filed a Petition for Benefits on March 25, 2008, but the employer and carrier did not respond at all. On May 7, 2008, the employer and carrier realized its error and paid a lump sum for past due benefits along with interest. The employer and carrier resumed paying benefits timely after it made the lump sum payment.

The claimant's attorney filed a Petition for Benefits with fees and costs based upon the past due benefits paid and the present value for all permanent total disability benefits and permanent total disability supplemental benefits. The adjuster testified that the payments stopped due to an administrative oversight and a new adjuster took over for a prior adjuster in January 2008.

Remarkably, the holding was that no attorneys' fees were due on the future value of permanent total disability and permanent total supplemental benefits because the employer and carrier had no knowledge or intent to permanently suspend those benefits.

This case is cited because it talks about the intent of the employer and carrier in making decisions. I believe it may have wide spread applicability.

9. Apportionment

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.

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 unrelated 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?

10. Major Contributing Cause

Bysczynski v. United Parcel Services, Inc., 36 Fla. L. Weekly D25 (Fla. 1st DCA December 28, 2010)

Claimant had compensable work injury in 2005, resulting in cervical diskectomy and fusion at C5-6, which included implantation of a fixation plate. Claimant subsequently returned to full duty. He required no treatment after he was placed at MMI on 11/23/05.

On 2/21/07 he injured his shoulder and reinjured his neck at work. He was diagnosed with cervical strain and radiculits. The claimant then had a partial shoulder replacement. Subsequently, he was diagnosed with disc osteophyte complex and degenerative changes at C6-7, with mild collapse of both neural foramina. The treating doctor recommended a cervical fusion at C6-7 (below the first fusion) and removal of the plate from the 2005 fusion. The treating doctor opined that the MCC of the need for 2007 surgery was the 2007 work accident, and not the 2005 work accident.

The E/C denied petition for 2007 surgery and hired an IME, who opined the current need for surgery was due to degenerative changes, but admitted the changes were likely related to the 2005 fusion.

EMA's report stated degenerative disc disease was the MCC of the current need for surgery. At trial, he clarified that that 2005 surgery likely caused the significant degenerative changes leading to the need for the 2007 surgery. He admitted the claimant likely had some degenerative disc disease before the 2005 accident, but essentially opined that the 2005 accident/surgery and the 2007 accident combined as the MCC of the current need for surgery.

Court found that the claimant's degenerative disc disease predating the work accidents was merely due to his age (i.e. 56) and, significantly, that the pre-existing degenerative disc disease condition did not independently require any level of treatment before or after the work accidents.

Holding: The only contributing causes for the claimant's need for surgery were "occupational in nature." Thus, the JCC erred in applying the MCC standard to deny surgery. Reversed and remanded to authorize the surgery.

Rule: Using the MCC standard to deny treatment based on pre-existing degenerative conditions is inappropriate if such pre-existing conditions did not independently require treatment prior to the work accident(s).