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TOP TEN TIPS

FOR CLAIMS HANDLING

IN

2017

Presented by: Eraclides, Gelman, Hall, Indek, Goodman, Waters & Traverso

Duration: 2 credit hours

Target audience: Adjusters/Employers

Course Objective: Instruct the student on tips in claims handling. To provide insight into how the recent case law affect claims handling.

Course Relevance: Practical tips and useful knowledge for adjusters to apply in their day to day handling of claims.

Study Method: Seminar

Name(s) of guest lecture(s): n/a

Name of school official or instructors in attendance: Instructors will be different from time to time – cv's has been submitted of all approved instructors.

1. Responding to a PFB to avoid fees (10 min)

A. Petition for Benefits must be filed with DOAH

1. 30 days

    1. 440.34(3) Regardless of the date benefits were initially requested, attorney's fees shall not attach under this subsection until 30 days after the date the carrier or employer, if self-insured, receives the petition.

2. 14 days

    1. 440.192 (8) Within 14 days after receipt of a petition for benefits by certified mail or by approved electronic means, the carrier must either pay the requested benefits without prejudice to its right to deny within 120 days from receipt of the petition or file a response to petition with the Office of the Judges of Compensation Claims.

    2. Fees do not attach until 30 days however per 440.34(3)

3. The benefits must be pled on PFB for fees to be owed

    1. JCC has no jurisdiction to award fees otherwise on benefits not listed on a PFB.

    2. 440.192(9) A petition for benefits must contain claims for all benefits that are ripe, due, and owing on the date the petition is filed. Unless stipulated in writing by the parties, only claims which have been properly raised in a petition for benefits and have undergone mediation may be considered for adjudication by a judge of compensation claims.

4. No response to the PFB is a denial

    1. Except for Statute of Limitations-

        440.19(4) Notwithstanding the provisions of this section, the failure to file a petition for benefits within the periods prescribed is not a bar to the employee's claim unless the carrier advances the defense of a statute of limitations in its initial response to the petition for benefits.

    2. Not providing the benefits is a denial

    3. Does not count as denial for 120 day rule either

5. Medical Bills

A. Unpaid Emergency Room Bills

1. Emergency treatment authorized by the employer (120 day issues)
    a) Must be for WC

2. Emergency treatment when authorized provider is closed

3. Emergency room treatment on denied claim more than 14 days after initial provision of benefits

-120-Day Rule applicability- pay and investigate

2. ONE-TIME CHANGE OF PHYSICIAN/CHOICE OF DOCTOR (10 min)

Choice of Doctor:

In Butler v. Bay Center, 947 So. 2d 570 (Fla. 1st DCA 2006), the court addressed the 2003 statutory amendments and found that the claimant must at least begin treatment with the initial physician before requesting their one-time change. The Court also found that the choice of a claimant's authorized treating physician is not a substantive right, but a procedural one. The Court applied the 2003 one-time change process to all claims, regardless of date of accident. The E/C no longer has to provide a list of three doctors to the claimant and the claimant may only change physicians once, no matter the variety of treatments needed.

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In Providence Property and Casualty v. Wilson, 990 So. 2d 1224 (Fla. 1st DCA 2008) the E/SA argued that the claimant was not entitled to his one-time change in physician, as he had been discharged by his authorized treating physicians, and was no longer in the "course of treatment," as required by §440.13 (f). The Court found that the claimant was entitled to one one-time change as a matter of law, and the fact that the authorized treating physician discharged the claimant "is irrelevant."

In Harrell v. Citrus County School Board, (25 So. 3d 675 (Fla. 1st DCA 2010)), the 1st DCA reversed the JCC's denial of a request for a "one-time change" of orthopedist. The Claimant had an authorized orthopedist. On October 9, 2008, she filed a formal grievance form with the E/C requesting authorization for a change of orthopedist. On October 14, 2008, the E/C sent a letter agreeing to authorize a new orthopedist stating that they were in the process of scheduling an appointment but they did not provide a particular doctor's name. On October 28, 2008, the E/C sent a second letter giving the claimant an appointment with one-time change doctor, which was scheduled for November 14, 2008. On November 19, 2008, the claimant filed a PFB for authorization of different orthopedist based upon the E/C's failure to timely authorize a new orthopedist. The JCC denied the request finding that the accident was not the major contributing cause of the need for treatment.

The 1st DCA reiterated the one-time change is mandatory, regardless of whether the initial authorized doctor opines that the accident is no longer the major contributing cause of the need for treatment. Moreover, there was no competent, substantial evidence supporting the E/C timely authorized the one-time change. The E/C's October 14, 2008 letter makes no mention of a specific doctor to treat, only that the E/C agreed to a one-time change. The actual doctor's name was not given until October 28, 2008. Section 440.13(2)(f), F.S. requires authorization of an alternative physician within five days of receipt of the written request. To timely respond, an E/C is not required to schedule an appointment, but must authorize at least one specific physician within five days of the request. Simply acknowledging a statutory entitlement is not sufficient. The statute requires the E/C to name at least a physician not professionally affiliated with the prior physician within five days of the written request.

In Hinzman v. Winter Haven Facility Operations, LLC, 2013 Fla. App. LEXIS 2478, the Claimant challenged an order of the JCC which ruled that the "5 days" in 440.13(2)(f) meant business days rather than calendar days.The First DCA reversed this ruling and held that the plain meaning of the statute reveals that the Legislature's intent was to provide the carriers with five consecutive days with which to authorize a one-time change of physician.

The Court reasoned that because the Legislature specified "business days" elsewhere in section 440.13, then the use of the unmodified term "days" refers to consecutive or calendar days. Even though the use of "calendar days" and "consecutive days" is prevalent in other parts of chapter 440, the Court held that the wording of those statutes was unrelated to the topic of a one-time change, and therefore their wording was unpersuasive.

*Accordingly, we now only have five consecutive/calendar days with which to authorize the claimant's request for a one-time change of physician.

In Gonzalez v. Quinco Elec., Inc, 171 So. 3d 153, 2015 Fla. App. LEXIS 10700, 40 Fla. L. Weekly D1617 (Fla. Dist. Ct. App. 1st Dist. 2015) the Claimant's Attorney first Appeared by filing a petition. Three weeks later Claimant's counsel filed a two page Notice of Appearance with a written request for a one time change on the second page. The adjuster did not see the request until the sixth day after it was filed. As soon as the adjuster noticed the request, she responded by offering an alternative physician but not the one Claimant requested.

The case went to a final hearing before JCC Thomas Sculco on the issue of whether the adjuster's response and offer of an alternative physician was timely. JCC Sculco found that under the circumstances, the "Notice of Appearance" did not trigger the E/C's obligation to authorize an alternative physician and that the E/C's authorization of the physician was valid when made.

On Appeal, the First DCA agreed with the JCC and affirmed his ruling that the E/C's response and selection of physician was timey under the circumstances. The court noted that "a claimant's request for a one-time change of physician under 440.13(2)(f) should not be inserted into a document that appears on its face to have exclusively another purpose. Rather, the request should be readily apparent, unobscured and unambiguous, to advance the purpose of placing the E/C on notice that such a request is being made in that document.

Roberts v. NPC International, d/b/a Pizza Hut/ Gallagher Bassett Services, Inc.
OJCC: 12-006733NSW

In this case E/C timely authorized Claimant's one-time change by naming a doctor within 5 days. While E/C did not have to schedule an appointment with the new doctor, compliance with 440.13(2)(f) requires an E/C to name at least one physician not professionally affiliated with the previous physician within five days of a claimant's written request. The JCC found that in this case, the E/C was diligent during the 30 day period between authorizing the new doctor, and that same doctor refusing to see Claimant.

However, when the doctor refused to see Claimant, the E/C had 2 obligations; (1) E/C had an obligation to select an alternative physician and an obligation to obtain an appointment with such alternative physician within a reasonable period of time; and, (2) E/C had an obligation to provide Claimant the name of an alternative physician within 5 days of the first doctor's decision not to accept authorization.

The JCC found that the E/C in this case did not satisfy it's obligation to select an alternative physician, E/C did not provide Claimant the name of such alternative physician timely nor did E/C act with due diligence in obtaining an appointment with the alternative physician nor was the call to Claimant to schedule an appointment within a reasonable period of time.

The JCC found that if E/C had notified Claimant it had selected a new doctor within 5 days of the previous doctor declining authorization, the E/C would have been in compliance with the statute.

By failing to authorize a one-time change and schedule an appointment with E/C's chose provider within a reasonable period of time, E/C waived the right to select such physician. Even though E/C has waived the right to select the physician, the Claimant may only choose a physician in the same specialized field as the previous doctor.

3. ADVANCES (10 min)

ESIS/ACE v. Kuhn, 104 So. 3d 1111 (Fla. 1st DCA 2012).

The Claimant was employed as a flight attendant with Delta for over twenty years when she injured her shoulder lifting an accordion style door. The accident was accepted as compensable and corresponding medical and indemnity benefits were provided. After a five month period of treatment, the Claimant was placed at MMI, assigned a permanent impairment rating, and paid impairment benefits. She continued to work for the Employer and continued to receive the same or greater pay following MMI. Over four years later, the Claimant filed a petition for benefits requesting a $2,000 advance payment under section 440.20(12), Florida Statutes. The basis asserted for entitlement to the advance was assignment of a permanent impairment and payment of the advance would be in the Claimant's best interest. The Claimant testified that she had no specific immediate need for funds, however, she would like to have money in the event an unexpected bill arouse. Further, she stated no additional monetary or medical benefits were ripe, due or owing. The JCC awarded the

advance payment advising that it was in the Claimant's best interest, relying Lopez v. Allied Aerofoam, 48 So.3d 888 (Fla. 1st DCA 2010).

The First DCA reversed the award. The court laid out a two-step inquiry for advance entitlement determination. First, the claimant must fall into one of three statutory categories: 1) not returned to same or equivalent employment with no substantial reduction in wages; 2) suffered a substantial loss in earning capacity; or 3) 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, a claimant is only entitled to be considered for an advance payment award.

The Claimant failed to show any connection of the request to a pending claim for benefits or that there existed a present need for the funds. Notably, the court stated, "the type of interest that is furthered by an advance under section 440.20(12)(c)(2) must at least have some plausible nexus to this purpose." Thus, as the Claimant failed to show a specific financial need related to medical or needed care, the award was inappropriate.

Worthy v. Jimmie Crowder Excavating, 100 So.3d 727 (Fla. 1st DCA 2012).

The Claimant requested a $2,000 advance payment under section 440.20(c)(12), Florida Statutes. In support of his request, the Claimant testified he had several personal bills that were in arrears and receipt of the funds would be in his best interest. The E/C defended against the award arguing the Claimant failed to provide evidence he was in need of exactly $2,000 as opposed to some lower amount. The JCC denied the Claimant's request.

The First DCA upheld the JCC's denial. Notably, the court advised that once a claimant has shown he has not returned the same or similar employment with no substantial reduction in wages as required by the statute, the JCC may provide the award, but is not required to do so. As the Claimant here failed to present evidence of why the amount of the advance, $2,000, was appropriate, adequate consideration of the Claimant's need could not be had.

Taylor v. Air Canada, 136 So.3d 786 (Fla. 1st DCA 2014)

The Claimant became ill after eating a lunch provided by her Employer during a training session, and the Employer/Carrier controverted compensability of the date of the accident. The claimant subsequently sought a $2,000.00 advance for the express purpose of taking the deposition of Claimant’s personal physician, who could testify as to the Claimant’s condition and treatment she received after she became ill. While the JCC found the claimant met the initial burden of showing a substantial reduction in wages as a result of her alleged injury and that she had not returned to work pursuant to the test espoused by ESIS/ACE v. Kuhn, 104 So.3d 1111 (Fla. 1st DCA 2012), the JCC denied the claimant’s request for an advance as the money’s intended use was for litigation.

The First DCA, however, reversed and remanded, as the second part of the Kuhn test, requiring adequate justification for the request, had been met. Specifically, the Kuhn court instructed that the need for the advance must be in furtherance of chapter 440's purpose, that is, "to address medical and related financial needs arising from workplace injuries." In the instant matter, taking the deposition of a witness who may advance proof of the compensability of a claim is such a need.

Strategies on dealing with a request for an advance

- Settlement in lieu of advance
- Resolve for a lower amount to assist in recouping
- No attorney fees for securing an advance City of Miami v. Mazur, 449 So. 2d 986 (Fla.1st DCA 1984) that there is no statutory basis for awarding a fee for securing an advance.

4. DEFENDING PTD (10 min)

Blake v. Merck & Company, Inc., (1 D09-5464, September 7, 2010) the 1st DCA just spelled out 3 different ways a claimant can prove they are entitled to Permanent and Total Disability Benefits (PTD)

(1) permanent medical incapacity to engage in at least sedentary employment, within a 50-mile radius of the employee's residence, due to physical limitation; 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 Claimant from engaging in at least sedentary employment when combined with vocational factors.

In Martinez v. Lake Park Auto Brokers, 1D10-4395 (Fla. 1st DCA April 29, 2011), the Claimant appealed an Order from the JCC denying PTD benefits. The First DCA remanded the case for the JCC to address the adequacy of the Claimant's job search. The First DCA noted Section 440.15(1)(b)(2006) provided that an injured worker may establish entitlement to PTD by establishing they could not engage in at least sedentary employment within a 50-mile radius of their home. The Court cited Blake v. Merck & Co. and indicated the JCC found the claimant's job search "does not establish that his inability to secure at least sedentary employment within a 50-mile radius of his residence was 'due to physical limitations.'" The finding addresses the first method listed in Blake. However, the First DCA noted the JCC failed to consider the possibility of the Claimant's entitlement to PTD under the second method addressed in Blake, "permanent work-related physical restrictions coupled with an exhaustive but unsuccessful job search." The Court went on to state that the job search must be conducted in good faith and it was the JCC's discretion to make that determination.

In Advanced Masonry Systems v. Molina, (4 So.3d 62, Fla. 1st DCA 2009), the Employer/Carrier challenged the award of PTD benefits and PTD supplemental benefits. Because the JCC's

finding the Claimant was PTD was not supported by competent substantial evidence, the First DCA reversed. The Claimant, Mason, fell and hurt his low back in the course and scope of employment on October 8, 2001. He underwent a lumbar fusion in 2004 and a second surgery in 2006. On February 1, 2006, the Claimant filed a Petition for PTD benefits. Prior to the hearing, the parties stipulated the Claimant suffered a qualifying threshold "catastrophic" injury. However, the E/C defended the Claimant retained a substantial earning capacity, he voluntarily limited his income and refused suitable employment. Ultimately, the JCC rejected all three of the E/C's defenses, even though the E/C had hired a vocational expert and an EMA testified the Claimant could work in a sedentary capacity. The claimant rejected a job offer because it only paid $8.00 an hour. He refused to attend English language classes paid for by the E/C.

The First DCA noted a Claimant who suffers a catastrophic injury is entitled to PTD benefits, but PTD benefits are precluded if the E/C offers conclusive proof the Claimant retained a substantial earning capacity and Claimants who refuse suitable employment are not entitled to PTD benefits unless the JCC finds their refusal was justified. The Claimant testified that he was in too much pain to attend employment interviews and that he could not work. There was an EMA who testified that the Claimant had an ability to engage in sedentary employment and the E/C hired a company to perform a re-employment assessment. Accordingly, the JCC's findings were not supported by competent substantial evidence. The First DCA held the JCC's rejection of the E/C's defenses were not supported by competent substantial evidence, so the award of PTD benefits was reversed.

Sarasota County School Board v. Roberson, 135 So.3d 587 (Fla. 1st DCA 2014)

The First DCA affirmed the JCC's award of permanent and total disability, and specifically rejected the Employer/Carrier's argument that the plain language of §440.15(1)(b) required the claimant to provide entitlement to PTD based solely on physical limitations. The claimant had sustained a wrist injury after an altercation with a student. Subsequently, the authorized treating orthopedic referred the claimant for a psychiatric evaluation, which the Employer/Carrier authorized. The JCC rejected the "plain language" position of the Employer/Carrier, finding that the pre-1994 PTD standard allowed consideration of psychiatric limitations. Further, the legislature's six month limitation on temporary benefits based on psychiatric restrictions per §440.093 (3) does not extend to PTD benefits. Lastly, the Court noted that Ferrell Gas v. Childers approved of the analysis of both physical limitations and vocational factors in determining PTD, therefore also contemplating consideration of psychiatric limitations.

5. FRAUD / MISREPRESENTATION (10 min)

Fraud and Attorney's Fees:

In Carrillo v. Case Engineering, (1D09-6401, February 11, 2011), the Claimant was working on a construction site and was injured. The 1996 date of accident resulted in temporary partial disability benefits and medical benefits that were paid by the Employer/Carrier.

The Claimant filed a Petition for Benefits requesting permanent total disability (PTD) benefits, attorney's fees, interest, and costs. The Employer/Carrier's defense to the PTD petition included the "fraud" defense (based on F.S. §440.09 and §440.105). The JCC stated the Claimant's testimony was evasive, unreliable and inconsistent but did not rise to the level of fraud, yet still finding for the E/C and requiring the Claimant to reimburse the other E/C's costs. The First DCA subsequently reversed the costs awarded and awarded fees to the Claimant to be paid by the E/C.

The First DCA quoted F.S. §440.34(3)(c), which states a Claimant may recover attorney's fees if the E/C denies compensability and the Claimant prevails. The court found when the E/C raised the defense of fraud they placed compensability/coverage at issue, akin to a denial under F.S. §440.34(3)(c). Consequently, when the JCC ruled Claimant's testimony did not "rise to the level of fraud" the E/C became liable for attorney's fees, because, as the First DCA opined, the Claimant's attorney preserved the right to receive worker's compensation benefits. *See* Chandler v. Centex Rooney Construction Co., 15 So.2d 837 (Fla. 1st DCA 2009).

Therefore, it is vital to thoroughly investigate the claim and determine if you have a valid misrepresentation defense before utilizing that in a hearing. Be mindful of pursuing an affirmative defense of "fraud", because "losing on the fraud defense" could mean a fee is due even if you prevail on all other issues.

Fraud-Video:

In Dieujuste v. J. Dodd Plumbing, Inc., 3 So. 3d 1275 (Fla. 1st DCA 2009), the JCC barred Claimant from receiving workers' compensation (WC) benefits based upon the JCC's finding that the Claimant made false statements for the purpose of receiving WC benefits. The 1st DCA reversed. The Claimant injured his knee and had two knee surgeries. He was given crutches and cane to assist in ambulation and the authorized doctor advised him to wean off the cane. The Claimant obliged, but on occasion used either the crutch or the cane. The Claimant testified at two depositions that he was capable of walking and standing without a cane or crutch and that he did so on a regular basis. He then used them when he felt pain. He usually brought the cane or crutch to his medical appointments. Surveillance revealed that as the Claimant was walking to enter the doctor's office, he was handed a crutch, which he then used. The E/C raised a misrepresentation defense. All the doctors testified that nothing on the video was inconsistent and the Claimant's activities were consistent with his objective painful knee condition. The JCC felt the Claimant portrayed himself, "much more severely disabled then the surveillance otherwise shows."

The 1st DCA held that activities observable on surveillance video can serve as a basis for a finding of misrepresentation. However, only **oral or written statements** can serve as the predicate for disqualification of benefits. (Section 440.09(4) and 440.105 (4) (b) 1-3. Because the WC statute expressly limits its disqualification provision to oral or written

statements, the surveillance has value only to the extent it contradicts or disproves an oral or written statement made by the Claimant. Here, the only medical evidence introduced established Claimant's condition was objectively verified, painful and consistent with the activities on the video. Absent supporting medical evidence, a JCC lacks the prerogative to deny a claim based on a medical finding premised solely on his observation of the Claimant. There was no competent, substantial evidence to support that the Claimant either orally or in writing misrepresented his physical conditions.

The court further explained in Lucas v. ADT Sec. Inc., 2011 Fla. App. LEXIS 11454, that if there is no evidence in the record that the claimant told anyone that he/she could or could not perform a certain behavior that his/her actions belied, then there is no basis for a finding of fraud. (Initially the DCA found no fraud because there was no oral or written statements to support fraud, but on Rehearing, the court was given an intake form that showed where the claimant rated her pain as a "5 out of 10." The court then affirmed the fraud finding based on this written statement.

Fraud- Fake Social Security Number:

In Arreola v. Administrative Concepts, 1 D08-4093, (August 14, 2009), the issue is the provision of a false social security number (SSN) on several occasions after the injury, in connection with treatment and whether this is within the parameters of section 440.105, F.S. The JCC denied all claims under 440.09 on the ground that the Claimant violated section 440.105. The 1st DCA held that there was competent, substantial evidence to support the JCC's finding and affirmed the decision. The JCC had to answer two questions to make his findings. The first is whether the Claimant made or caused to be made false, fraudulent or misleading statements. The second is whether the statement was intended by the Claimant to be for the purpose of obtaining benefits. There is no requirement that the misrepresentation be material in actuality, rather, that the Claimant made it with the intent to secure benefits. The JCC found that on two occasions the Claimant used a fake SSN after the accident (at a pharmacy and when he was interviewed by E/C's investigator). The only question left involves intent. Claimant argues that the provision of the SSN was solely as a means of identification and he had no intent for it to be used to obtain benefits. Had the JCC bought that argument, the Claimant would have won his case. However, the Claimant's state of mind is a question of fact for the JCC to decide and the JCC did not accept that account. Claimant then attempted to argue the real reason for the denial of benefits is because he was an illegal alien. The 1st DCA stated that illegal aliens are entitled to benefits under the WC law, but must comply, like everyone else, with the statute to obtain benefits.

In Matrix Employee Leasing, Inc.v. Hernandez, 975 So. 2d 1217 (Fla. 1st DCA 2008), the claimant used a false SSN on his application for employment, but did not use a false SSN on the PFB nor did he present the false SSN to authorized medical providers. Therefore the claimant was not disqualified from receiving workers' compensation benefits as the result of the use of a false SSN to secure employment, because the false SSN was not used for the purpose of procuring workers' compensation benefits. See §440.09(4) (a).

(10 MIN BREAK)

6. EFFECTIVE USE OF DWC-19's (to avoid P and I) (10 min)

SUSPENSION OF TEMPORARY BENEFITS
69L-3.021 (3)

If the employee refuses to report the DWC-19 within 21 days after receipt of the request, payments of workers' compensation disability benefits for temporary total, temporary partial, permanent, total or permanent total supplemental compensation shall cease until such time as the employee furnishes the signed form.

EVIDENCE OF RECEIPT OF FORMS

In Perdue v. Sebring Marine IND. INC. and Sentry Claims Center, (1st DCA 2011), the Employer/Carrier sought to avoid payment of the requested TPD benefits on the grounds the form had not been completed. On appeal, the claimant argued that there was no evidence that the DWC-19 forms for the relevant time period were sent to the claimant. The DCA pointed out that the records reflected that the adjuster for the Employer/Carrier unequivolically testified that the EER forms were not sent. The First DCA held that because the employer/Carrier sought to avoid payment of the requested TPD benefits on grounds the forms had not been completed, the Employer/Carrier had the burden to prove it sent the forms to the claimant. The First DCA reversed the JCC order with instructions to award TPD benefits along with penalties, interest, costs and attorney's fees. Also see, Republic Waste Services, INC/East Bay Sanitation Services and CCMSI v. Ricardo (68 So. 3d 934 (2011), the DCA noted, it will always be within the knowledge of the claims-handling entity as to whether it sent the injured worker DWC-19 forms, and should not be hard to prove, if it has been done. In the circumstances, we see no good reason to burden claimants with proof of a negative. The Court found the E/C did not prove that the forms were ever sent to the claimant and thus failed to prove that any duty ever arose on the claimant's part of complete and return the forms.

Did we send to the correct address?

PENALTIES AND INTEREST

§440.20(6), which deals with penalties, interest only comes into play when you are later than 7 days after the payment is due

You are paying TPD in advance and if you wait 21 days later to actually pay, you are already late in making a timely payment.

BE CAREFUL - Republic Waste Services, Inc. & CCMSI v. Ricardo, 68 So. 2d 934 (Fla. 1st DCA 2011), if the Employer/Carrier *fails to prove the DWC-19s were provided to the claimant*, failure to return the forms does not prevent an award of penalties and interest.

7. IMPAIRMENT BENEFITS (10 min)

A. Impairment Benefits

1. 2003 Statutory Formula

2. 75% versus 37½%- calculated weekly, paid biweekly

440.15(3) (c) All impairment income benefits shall be based on an impairment rating using the impairment schedule referred to in paragraph (b). Impairment income benefits are paid biweekly at the rate of 75 percent of the employee's average weekly temporary total disability benefit not to exceed the maximum weekly benefit under s. 440.12; provided, however, that such benefits shall be reduced by 50 percent for each week in which the employee has earned income equal to or in excess of the employee's average weekly wage.

3. Overall MMI- reclassifying indemnity, watch out for Penalties and Interest
4. No voluntary limitation of income argument

B. DWC-19 and IMPAIRMENT BENEFITS

69L-3.021 (4)

For dates of accident on or after October 1, 2003, upon the request of the claims-handling entity, any employee eligible for impairment income benefits shall complete, sign, and return Form DFS-F2-DWC-19 within 21 days after receiving it to report all earnings. The claims-handling entity may require the employee to send Form DFS-F2-DWC-19 no more than once a month. If the employee refuses to report earnings within 21 days after receipt of the request payment of workers' compensation disability benefits for impairment income benefits shall cease until such time as the employee furnishes the signed form.

If the claimant is **still employed** and returned to work for your insured, then the determination should be easy as a simple call to the payroll department.

If the claimant **has left or is no longer employed by OUR employer**, then the best practice is the use of the DWC-19 to determine if the claimant is working and earning at least his or her average weekly wage.

8. DENIAL LANGUAGE TO PROTECT AGAINST LIABILITY CLAIMS (10 min)

A. If possible avoid the phrase:

1. …not in the course and scope of employment

Mena v. J.I.L. Constr. Group and Slorp Constr. Co., 79 So.3d 219 (Fla. 1st DCA 2012).

The Claimant, while working for on a job, a portion of which was subcontracted by J.I.L. to Slorp, fell off of a roof truss and incurred several significant injuries. The Claimant filed a claim for workers' compensation benefits against both entities. J.I.L. defended against the workers' compensation claim on the grounds that no employer/employee relationship existed, and failure to timely report. Slorp denied the claim for workers' compensation benefits advising J.I.L. was the statutory employer and thus, responsible for benefit provision. Thereafter, the Claimant dismissed his petition and filed a civil negligence suit against both Slorp and J.I.L. Both J.I.L. and Slorp asserted immunity and exclusive remedy in response. The trial court granted summary judgment, dismissing the civil suit in favor of both Employers.

The First DCA reversed as to J.I.L. but affirmed dismissal as to defendant Slorp. The court held, "where an employer denies a claim for workers' compensation benefits on the basis that the injury did not occur in the course and scope of employment, or that there was no employment relationship, the employer may be estopped from asserting in a later tort action that the workers' exclusive remedy was workers' compensation." For estoppel to apply, the language of the claim denial must be irreconcilable with assertion of immunity. In the case at hand, J.I.L. clearly denied the initial claim for benefits stating no employment relationship existed while Slorp denied claiming the Claimant was an employee, but of J.I.L.'s. Therefore, it is impermissible for J.I.L. to first state the Claimant was not an employee and then defend on the converse position that because the Claimant was an employee, he was limited to pursuit of workers' compensation benefits.

9. PREPARING FOR YOUR DEPOSITION (10 min)

Don't fear your depo. Embrace it as an opportunity to really dig into the file, clean up issues, and come up with a plan to resolve the whole claim or at least the remaining issues before trial. Sometimes the reason something was denied has changed, and if so, providing the benefit and stipulating to fees will cancel the deposition.

Some of the keys to having your deposition go as smoothly as possible:

1) Be prepared. Have the file organized and printed. Conference with your defense attorney as to the issues and likely questions.

2) Have the PFB's, responses, denials, wage statement and payout printed and ready. Almost every deposition will go over these documents.

3) Be professional and polite, not combative. Even if the claimant's attorney goes low, take the high road and don't sink to their level.

4) Know the authorized providers and the information about any 1-time changes

5) Know the issues on the PFB's and the reasons for the denial.

6) Have settlement authority so you can discuss that with OC.

Your depo is unavoidable in most cases, so make the best of it.

10. <u>Westphal case</u> (10 min)

A. Both TTD and TPD are now 260 weeks

B. PTD is not ripe until overall MMI

1) In <u>Jones v. Food Lion</u>, Case No. 1D15-3488 (attached), the claimant filed for PTD at the expiration of 104 weeks, even though he was not at MMI. The case was heard by the JCC before the Fla Sct decision in Westphal, so the JCC found the claim for PTD was not ripe. The 1st DCA agreed that PTD was not ripe, but for the reason now that he is eligible for 260 weeks of TPD.

The 1st DCA concluded that the Fla Supreme Court's reasoning also encompasses any "gap" created by the 104 week cap on TPD. Similar to <u>Westphal</u>, a claimant who was receiving TPD and reached the 104 week-cap would suffer a reduction in benefits and would be cut off from the ability to receive any disability benefits at all.

2) However, if not at overall MMI, can file for PTD if one of the conditions for which the claimant is at MMI would qualify him alone for PTD.

C. Entitlement to temporary indemnity now for dates of accident from 1/1/1994-9/30/2003

Fla statute 440.15(3)(c) Duration of temporary, impairment and supplemental income benefits- The employee's eligibility for temporary benefits, impairment income benefits, and supplemental benefits terminates on the expiration of 401 weeks after the date of the injury.

<u>HOLL v. UNITED PARCEL SERVICE and LIBERTY MUTUAL INSURANCE</u>, Case No. 1D13-2745. (Fla 1st DCA 2014)

(10 MIN BREAK)