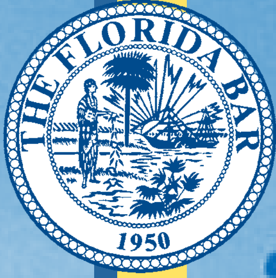

The Florida Bar
Workers' Compensation Section

www.flworkerscomp.org

News & 440 Report

How to Seek Review of Patently Unreasonable Fees after Kauffman

Petitions for Rule Nisi Under Section 440.24

Hidden Dangers of WC Denials and ERISA Group Health Subrogation Claims

Invoking "the Rule" During Depositions? Absolutely "Maybe"

Process, How Much is "Do"?

Volume XXXI, No. 3
Spring 2012

News & 440 Report

The NEWS AND FOUR-FORTY REPORT

is published by The Florida Bar Worker's Compensation Section

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Statements or expressions of opinion or comments appearing herein are those of the editor(s) and contributors and not of The Florida Bar or the Section.

Cover Shot:

Black birds, emblematic of claimant lawyers, starving in a dying tree which bears no fruit. – the Editor.

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Section Calendar

2012 Schedule of Events

April 12-13 — **2012 Florida Bar Workers' Compensation Forum**
Omni Orlando Resort at ChampionsGate
Contact: Toni Greer, WCCP Association HQ
(toni@ae21.com)

May 14 — **Workers' Compensation Telephonic Seminar**
Tuesday, 12:00 noon – 1:30 p.m.
Email notice to members in May

May 17-20 — **Workers' Compensation Section Executive Council Out of State Meeting**
The Sofitel, New York

August 21 — **FWIC Conference - Orlando**
Workers' Compensation Section Executive Council Meeting and Elections
Orlando, World Center Marriott

For more details, visit www.flworkerscomp.org.

Message from the Chair

Planning to Meet, Meeting to Plan

By Jeffrey I. Jacobs, Esq., South Miami, FL

The Executive Council last met on January 27, 2012.

The **Workers' Compensation Forum** (formerly the Board Certification Review Course) is scheduled for April 11 to 13, 2012 at the Omni Orlando Resort at ChampionsGate in Orlando. Section members receive an e-mail with the Forum brochure and registration information each week. The Forum features many outstanding speakers including **George Kagan, Steve Kronenberg, Chris Smith, Glen Wieland, Mike Winer** and **Bill Rogner** to name a few. The Forum covers the standard core workers' compensation subjects in addition to topics such as handling complicated settlements and employment law causes of action flowing from work related injuries. **Allison H. Hauser**, Program Chair of the Forum, the steering committee and faculty have work tirelessly to ensure the Forum is the preeminent workers' compensation seminar. The Forum routinely attracts over 400 attendees. If you have not registered yet, you should do so immediately.

The Executive Council unanimously voted to award **Herb Langston** the *Frierson-Colling Professionalism Award* for demonstrating outstanding leadership and professionalism. The presentation of the award to Herb will be made on Thursday, April 12, 2012 during the Forum. We congratulate Herb and thank him for his years of outstanding leadership and professionalism.

Dawn Traverso, Continuing Legal Education Chair and Chair Elect, has done an outstanding job organizing the annual winter seminar that encompasses a variety of workers' compensation topics. The winter seminar will be held at The Viceroy in Snowmass, Colorado from February 26, 2012 to March 1, 2012.

Martin Leibowitz was elected to the Executive Council to fill a vacancy for the 1st district's defense seat. There is presently an opening for the 5th district's defense seat. All interested applicants should submit their name to **Arlee Coleman**, The Florida Bar's Section Administrator, as soon as possible.

Mike Winer is soon stepping down as the editor of the *News & 440 Report*. Mike has performed a tremendous job as editor. On behalf of myself and the Section, I would like to thank Mike for his hard work and dedication. **Jeff Appel** was elected as the next editor of the *News & 440 Report*. Congratulations, Jeff.

The Executive Council is working on several projects. The Judiciary Committee, Chaired by **Leo Garcia**, is working with the Conference of Judges of Compensation Claims to update the *Guidelines for Professional Conduct* last published in 1997. Martin Leibowitz, Chair of the Technology Committee, is in the process of updating the Section's web site.

Subsequent to the meeting on January 27, 2012, the Legislature amended House Bill 971. The amended bill abolishes the statewide nominating commission for judges of compensation claims established by section 440.45, Florida Statutes. The statewide nominating commission for judges of compensation claims is composed of 15 members. The Governor selects 5 members, one of each who resides in each of the territorial jurisdictions of the district courts of appeal, and the Board of Governors of The Florida Bar selects 5 members, one of each who resides in each of the territorial jurisdictions of the district courts of appeal. Those 10 members elect the remaining 5 members, one of each who resides in each of the territorial jurisdictions of the district courts of appeal. If passed into law, the judicial nominating commission for the First District Court of Appeal would nominate judges of compensation claims. The Section's legislative positions support any changes in the current workers' compensation law that would ensure the independence of the judges of compensation claim's ability to discharge the duties of their office in the adjudicatory process, including a reappointment process that promotes and ensures the independence of the judiciary. The Florida Bar required a specific legislative position for the Section to oppose the amendment to House Bill 971. The Executive Committee adopted on behalf of the Section a new legislative position which states that "The Workers' Compensation Section opposes any legislation that abolishes the statewide nominating commission for judges of compensation claims." The Florida Bar immediately approved this legislative position. **Fausto Gomez**, the Section's lobbyist, may comment further on the status of House Bill 971 and other pending legislation.

The Executive Council next meets on May 19, 2012 and will continue to work diligently in the interests of the Section.

Editor's Comments:

Taking my ball and going home

By Mike Winer, Esq., Tampa, FL

Dear Friends and Colleagues:

So this is it.... the last time you get to hear me pontificate, the last time you have to put up with my nonsense. I'm taking my ball and going home. My duties as editor are officially over. Meet me at the bar. Drinks on me. With those robust guideline fees equating to as much as $3 to $4 per hour, I can afford to buy you all a thimble of Old Milwaukee. So drink up Johnny! But hurry, for the chalice of comp runneth under.

I have kvetched and complained for far too long at the injustice unique to the workers' compensation system, both for injured workers and for their lawyers. In every aspect of law, I can freely bargain with my client, in an arm's length transaction, for a fair and reasonable fee for my services. However, if I do so in a comp case, I am a felon. This grates me to no end. That the E/C can spend endless financial resources to defend the most tenuous of claims with the only repercussion being modest interest and penalties and an even more modest fee being owed irks me even more. Like to many of you, I take great pride in what I do, work hard to be the best I can be and to provide a quality and competent level of legal service to my clients. These efforts deserve fair and reasonable compensation, one which permits our financial survival. In the long run, as John Maynard Keynes once observed, we are all dead. In the short run, lawyers have offices to run, mortgages to pay, and children to educate." *United States Department of Labor v. Triplett*, 494 U.S. 715, 724-725 (1990) As this passage points out, the private practice of law is still a business. A lawyer who offers his time and the benefit of his experience should be able to receive compensation for his efforts. My efforts to achieve this goal will continue through the courts. While you have seen the last of me as editor, you have not seen the last of me in the circuit or district courts, where the pursuit of justice and fairness will continue.

I had intended for my last comments as editor to be free from political discourse. That ain't gonna happen. I was mortified to learn that two of the several bills related to workers' compensation had passed - one permitting excess profits to be retained by carriers, and a second removing the annual report requirement by the Department of Financial Services (DFS). A more detailed analysis of this is contained in an excellent letter to editor by Glen Wieland and in the equally comprehensive legislative report by our lobbyist, Fausto Gomez. Am I being a bit conspiratorial in seeing these bills as a nefarious move which amounts to a license for insurance companies to steal from employers? Let's take a closer look. The annual report included information regarding claims, such as the nature of the injury, cause of the injury, body location of workplace injuries, and medical data. Taken in a vacuum, the repeal of this does not seem too deleterious. However, with the simultaneous passage of the repeal of excess profits, a more sinister motive appears. Workers' Compensation insurance prices are set by rates using data provided by the National Council on Compensation Insurance (NCCI) . In other words, the fox guards the henhouse. There is no competitive market for pricing in a coverage that is mandatory. One could legitimately argue that the annual report by DFS provided critical, objective data regarding the basis for insurance rates, in the process offering much needed oversight to protect consumers. On August 18, 2011, NCCI delivered its annual workers compensation rate filing to the Florida Office of Insurance Regulation (OIR). Based upon its review of the most recent data available, NCCI proposed an overall workers compensation rate level increase of 8.9%. Would the annual report by the DFS have at least provided an objective measure by which to, in part, justify such a request and future requests for rate increases? I would humbly suggest so. Now, the requirement for the report is gone and along with it, the obligation of the carriers to return a portion of the excess profits to policy holders.

For over 30 years, insurance company profits have been subject to an audit by the Insurance Commissioner. When the audit reveals that an insurance company has earned profits that are considered "Excess" as defined by statute, the insurance company must return the excess to to its customers and policy holders, who now become the losers in this latest round of legislative horse-trading and shenanigans. The other loser is the injured worker (and his attorney), who will invariably be blamed when the next round of rate hikes is requested by NCCI. As of 2008, the Florida Workers' Compensation System was only returning 43.7 cents of each premium dollar in claim payments to injured workers. I believe that number has decreased further.

• *Editor's Comments*

The national average in 2008 was 61.8 cents of each premium dollar. The above information comes directly from the 2009 report from the Consumer Advocate's Actuary, Steve Alexander.

Compounding the issue was the failure of the legislature to pass the bill revising the amount of reimbursement for prescription medications of workers' compensation claimants by providing that the reimbursement amount is the same for repackaged or relabeled drugs as for non-repackaged drugs. The intent of this bill was to kill a practice by certain physicians, who treat workers' compensation claimants, in which they simply repackage the medications they prescribe for their patients at significantly increased costs. The injured worker gains nothing from this- the medication he receives is the same. However, the carriers bear the cost of this increase, a cost which is ultimately passed along to the policy holders (employers). Both National Council on Compensation Insurance (NCCI) and the Office of Insurance Regulation (OIR) argued that if the bill passed, a reduction in workers' compensation premiums would be in order. Unfortunately, that did not happen.

So when the next rate increase request comes, and invariably it will, injured workers will again be blamed. And how will the legitimacy of it be measured? Not by the objective data from the annual report. Meanwhile, the insurance industry sits back and counts its money, knowing that the excess profits it earns are its to keep and that its further requests for rate increases will have less objective data to overcome. The net result- higher rates due to less oversight.

Will Gov. Rick Scott sign this into law? "Get to Work," Rick! After all, did your "7-7-7" plan not focus on getting Floridians back to work? It did. Do higher workers' compensation insurance rates accomplish that objective? They do not. Does Rick Scott care enough to veto this? I bet he doesn't. Time will prove me right or wrong.

I guess I've just "had enough and can't take it anymore." With that in mind, I hand the editorial reigns over to Jeff Appel, a bright legal mind who has been dedicated to this practice for over 15 years. Jeff will bring fresh ideas and the same thought provoking commentary and educational articles you have grown to expect. He has handled "both sides" and may also bring the objectivity I have oft been accused of lacking.

Your newsletter has come a long way over the past 5 years. Not too long ago, this publication was just a few pages printed on newspaper. We have modernized the process, sending a sophisticated electronic magazine completely dedicated to the practice of workers' compensation. In so doing, the Section has saved thousands of dollars annually and saved even more trees. I urge you to look at some of the other Section publications of the bar and feel a sense of pride in what your Section has accomplished. The quality of scholarly articles is unmatched. The case law summaries are comprehensive and complete. I would like to think that simply reading this publication cover to cover every quarter would provide the workers' comp practitioner with all the news and info necessary to remain competent in this practice.

Reaching such lofty heights was the by-product of the hard work and dedication of many. Standing on the shoulders of giants, a foundation was laid by those before me who created this publication and then ensured its consistency and quality. We built upon that legacy over the past five years. So many of you contributed so much by authoring articles providing useful information on all things related to Chapter 440 and the practice of law. As Jeff Appel noted, "this is your publication," and in the end, it was your contributions that made this publication great. To all of you over the past five years who have answered the call of duty or volunteered on your own accord to put pen to paper (or thumbs to keyboards) and write an article germane to our practice, I thank you. Your selflessness has elevated our profession and shown the "outsiders" that there is dignity and complexity in what we do. You have promoted professionalism and competence of our Section. I would also be remiss if I didn't offer a final shout out to the "regular" contributors. Roger Turner's case law summaries are horn-book quality. Read them and you are up to date on all you need to know. Chief Judge David Langham, never satisfied with doing just his job, has gone above and beyond the call of duty in offering a steady stream of material, all geared toward making every lawyer in this section, whether claimant or defense, the best lawyer he or she can be, in the eyes of the judges, their clients and their peers. Lastly, Arlee Coleman, our section liaison with the bar, has been always at the ready, behind the scenes, helping to transform a jumbled mess of legal articles into a slick electronic magazine.

So I bid you all farewell and thank you for your interest and readership. See you at the bar!

Best Regards,

Mike Winer, Esquire
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Letter to the Editor:

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February 1, 2012

Mr. Michael J. Winer
Editor-In-Chief
110 North 11th Street, Floor 2
Tampa, FL 33602-4223

RE: Case Law Update, News & 440 Report, XXXI No. 2, Fall 2011

Dear Mr. Winer:

I cannot tell you how offended I was reading the "Editor's Note" at page 42 of the above issue which states "This opinion illustrates the court's unfortunate ignorance of the system. Anyone who has done workers' compensation or any injury related cases for long enough will tell you that the defense can find an expert to say anything…." (emphasis added). As a defense attorney and Board Certified Workers' Compensation attorney, I am appalled that this kind of biased opinion was allowed in a publication I support with my section and probably my Florida Bar dues. What happened to objectivity??? Fair and honest reporting??? Are the Case Law summaries similarly biased in their reporting depending on whether the author is a Claimant attorney or a Defense attorney? If so, perhaps that disclosure should be made or perhaps just change the name to "Claimant's News & 440 Report"?

If a retraction has been printed, I apologize for this tirade. However, if there has been no retraction of these defamatory comments by an unidentified "editor", there should be.

Sincerely,

Betty D. Marion

BDM/rl

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Editor's Response to Betty Marion:

First, thank you for your interest in the *News & 440 Report*. It has always been one of the missions of this publication, under my role as editor, to provide a forum for the exchange of ideas and discussion of our practice. I welcome comments such as yours, though they seem a bit harsh to me. Apparently, I my editorial comments struck a nerve with you. It's at least nice to know that someone is listening out there. To specifically address your comments, first, as noted by the opening sentence of your letter, the comments regarding the case of *Lucas v. ADT Security / Sedgwick CMS* came from me as the editor of this publication. I am the "unidentified editor" from whom you seek a retraction. My name and address appear on the inside jacket of each edition, and have done so for five years, clearly denominating me as editor. Thus, the comment in the case law summary which was clearly labeled in bold as "**Editor Comments**" should fairly be attributed to me. I'm not sure how this could be labeled any more clearly than it was. I will leave it to incoming editor, Jeff Appell to decide if he chooses another format by which to label his editorial comments.

Despite your request for a retraction, I decline to do so. I stand by my comments. First, as editor, I always took it as my right, if not my duty, to provide commentary, opinions and my take on various topics. I did just that in this instance. My opinions were clearly labeled as such and kept separate from the objective case law summaries provided so capably by Roger Turner so as to not co-mingle the two. The reporting of the case summary itself by Mr. Turner was "fair and honest." As for my comments, you are free to disagree with them as reasonable minds are prone to do, but to remove them from the public discourse would be to undermine the very purpose of the *News & 440 Report*– to provide a forum to exchange ideas and thought.

Second, I stand by the comments themselves. I wrote that "Anyone who has done workers' compensation or any injury related cases for long enough will tell you that the defense can find an expert to say anything." I maintain the opposite is also often true, that many claimants can equally find an expert to say anything. That is the nature of litigation. Experts witnesses, who derive substantial sums of money from reliable and consistent referral sources, are prone to provide opinions that favor the source who hired them. This holds especially true on the defense side, where the E/C gets to pick the treating doctor and then the IME. The process affords ample opportunity for financial relationships to develop between doctor and carrier. Simply put, certain experts are smart enough to not bite the hand that feeds them. The *Lucas* case presented a real life example of this. I lament that the DCA did not recognize this. In retrospect and in fairness and deference to the DCA, this perhaps was due to a faulty record or failure to make the appropriate argument by counsel. I do retract my indictment of the court's misunderstanding of the day to day operation of the WC system to that extent. Regardless, I continue to maintain that the DCA got the case right the first go around when it found that misrepresentation must be based on actual, false, fraudulent or misleading oral or written statements for the purpose of obtaining benefits. A misrepresentation defense, with the stiff penalty of total forfeiture of benefits, should require more than the doctor selected by the carrier simply stating that "the patient did not give full effort" or "the patient's subjective complaints are out of proportion." That is the doctor's subjective assessment only. How could he truly measure her pain? In denying claims for "fraud," the E/C should have the burden to show that the claimant has actually asserted things that are demonstrably false, and those assertions must be made with the intent to obtain benefits. I echo those sentiments in this, my last comments as editor.

Guest Editor's Comments:

The News & 440 Report is Your Forum

By Jeff Appel, Esq., Lakeland, FL

I am grateful to Mike Winer for the opportunity to become involved with the News & 440 Report. Mike has dedicated innumerable hours to our section's newsletter and the quality of the product reflects his hard work. I have examined other section newsletters and I am as certain as an EMA opinion that ours is top notch. Thanks to Mike and the executive council's vote, I will be taking the reigns as editor as of the next issue. I will try not to muck it up.

In preparing to take on this challenge, I have been pondering the purpose of the Report. As I see it, the the purpose is not easy to singularly define. Providing a forum for section members to discuss and debate important legal topics has been central to the Report in the past. This will continue and we will welcome and publish original content contributed by our section members. Disseminating vital information about the practice is also a necessary function. If anyone involved in this practice has information that needs to be shared, please send it to me and we will get the word out.

As I see it, another job of the Report is to promote camaraderie in our practice. I hope to enhance the newsletter's use toward this end. Admittedly, this goal is a self-serving attempt to deal with my personal gripe about the state of our practice and the impact technology is having. I expect I am not alone in my love-hate relationship with technology as it relates to the practice of law.

I am unquestionably grateful I am not hand writing this guest editorial by candlelight without climate control (especially because it is 6am and I am in Snowmass, Colorado at the section's winter retreat which everyone should attend...more on this below). On the other hand, the pace and impersonality technology promotes is sometimes loathsome. I acknowledge my share of the blame in allowing technology to take this toll. Like an addict, I cannot quit and my needs escalate. My life revolves around emails, texts, instant messages, and faxes. Actually, faxes are now way too slow. Questions must be answered quickly. Information shared instantaneously. I have no time for contemplation, reflection, or studied analysis. Others surely share the sentiment.

Technology has created such fantastic ironies. I have access to an ocean of information but no time to delve below the surface. I interact with people constantly during the day, but rarely have a personal interaction. The time I save with technology is filled with more time-taking activities.

But what can we do to push back the tide? I have a few suggestions.

Attend live functions. Spend some time with your colleagues at seminars, conferences, and social activities. I will gladly promote such activities in the Report. Send me the information, notice or invitation and I will publish it.

Schedule breaks. We all need some time off. Don't make taking time off difficult for your colleagues. Leave that job to our clients.

Get personal. No, I don't mean you should refer to opposing counsel's lineage in a derogatory way. But do take the time to personally interact on your cases together. Take time to attend events in person. Call on the phone instead of email. You know what I mean.

Give the threat of "sanctions" a rest. *Res ipsa loquitor.*

Get your paralegals involved. We need to enhance section membership to maintain section activities. Paralegals should become section members. Encourage them to personally interact with other paralegals. We all have been in a situation of stress created by paralegal interaction on a case where the attorneys probably would have worked it out. Some JCCs criticize the role of paralegals when it comes to resolving disputes. This is reflected in the constant reminders to personally confer on motions which may seem like an impractical burden in a fast paced practice. However, I contend that if we encourage our paralegals to participate in the section as we would a new associate, they can become more effective on our cases and we would all face less of those "miscommunication" situations.

If anyone has a paralegal who would like to contribute or organize paralegal contributions from around the practice, I would welcome the opportunity to add a regular segment for paralegals to the publication.

These are just a few of my suggestions. Most of you section members are wiser than me. If you have an idea about making our practice better, please share it with everyone through your *News & 440 Report*. Although I will be editor and making comments from time to time, this publication belongs to the section. Please keep contributing articles. Promote opportunities for social

• *Guest Editor's Comments*

interaction. Help us all get to know each other better - write up something personal about your colleague, friend, JCC, mediator or others involved in the industry (try to be nice). This is your forum: a refuge from clients, a place to speak your mind, an opportunity to connect with others in the business. Also, send me your comments, critiques, suggestions. I will be glad for the help.

Finally, as I sit here watching the snow "dump" as they say here in ski country, I am happy to realize that I am probably snowed in for a few extra days. I will be lucky to spend this time with some outstanding colleagues, some of whom are old friends and some are new friends. I encourage any section member who is serious about enhancing our practice to join me next year at the winter retreat. Unlike any other conference (and it should not even be called a conference except for tax purposes), I look forward to the morning sessions where a wealth of workers' compensation experience gathers for extremely candid discussions of highly relevant topics. Each year the retreat is held in a premier ski destination with significantly reduced accommodation rates. This year several families took advantage and brought their kids-- many of whom loved going to ski or snowboard school each day. With babysitting available, my hard working colleagues were able to spend some quality time away from their well worn-out children in the evenings. I'm bringing mine next year for sure. Section chair-elect, Dawn Traverso toils arduously to organize the retreat and its quality matches her effort. Thanks Dawn! Plans for next year are already in progress. As soon as the date is available, mark the week off your calendar and you will have something to look forward to all year.

I apologize for the unabashed plugging of the winter retreat but it truly is an event worthy of your time and hard earned money. I will do my best to write something controversial and/or witty for the next issues as a proper editor should.

— Jeff Appel, Guest Editor

Letter to the Editor:

Insurance Companies Want to Collect "Excess Profits?" Really?

By Glenn Weiland, Esq. Orlando, FL

It is hard to believe that the Florida House has passed and the Legislature is trying to pass a bill allowing insurance companies to collect "EXCESS PROFITS". Up to now, the insurance company profits have been subject to an audit by the Insurance Commissioner. If that audit reveals that an insurance company has overcharged its customers and earned profits that are considered "Excess" as defined by statute, the insurance company has been directed to return the "EXCESS PROFITS" to its customers and policy holders. The Office of Insurance Regulation reports that the workers' compensation carriers have returned more than $200 million in excess profits to their policyholders since 2003. $200 million dollars in "Excess Profits" have been given back to the businesses in Florida that obviously overpaid on their premiums because of the current law. Yet, the Florida Legislature and our elected officials are actually trying to remove the law that protects businesses and policy holders from carriers that are earning "Excess Profits." Most people do not object to any company earning profits. But an insurance company that has "Excess Profits" from premiums for insurance coverage that is mandatory for businesses to carry in Florida should have to return some of those "Excess Profits" to its customers and policy holders. When citizens and companies in Florida are required by law to purchase insurance coverage, the state should regulate and audit the insurance companies to protect businesses and consumers from being overcharged. Since Workers' Compensation insurance prices are set by rates using NCCI data, there really is not a competitive market for consumers and therefore there must be government oversight to protect consumers.

It is very interesting that the carriers want to collect "Excess Profits" and still ask for rate increases claiming that they are losing money. If they have

continued, next page

lost money since the reforms of 2003 and need rate increases, then why was there over $200 million returned to consumers over that same 8 year period of time? If the legislature would place everyone under oath who presents data, testimony or documents to the state to review, I think we might find the truth somewhere regarding what business should be paying in Florida for compensation coverage. Businesses have failed to question their own carriers about why the premiums need to go up.

The need to increase premiums is certainly not because benefits are up. Doctors will tell you that it is not that they are being paid more. Pain management doctors will tell you that they cannot sell pain medications from their offices any more so they aren't to blame. So what is costing more? Managed care, nurse case managers who are paid more than the doctors and the carriers call those expenses medical expenses when they are really overhead and case investigation costs. Could it be the hospital expenses? They will tell you they are not to blame. Is it the claimant who can't select his doctor, even select his one-time change doctor or have any say in his or her medical care, no I think not. Well, what is left, I guess we must try to find a way to blame the lawyers. Well, attorneys who represent injured workers have had their fees capped and reduced by over 50% since 1994. So ask yourself, who is left to blame?

Isn't it time we made the two changes that have not been made since 1979? Number 1: Do not allow NCCI to provide the sole source of data by which the state reviews and sets premiums. Number 2: De-regulate the sale of insurance rates go to a open competitive market with the Insurance Commissioner being able to review rates to make sure that the largest carriers do not intentionally write the workers' compensation policies as loss leaders to drive other carriers out of business. And, make each insurance company have to submit its own rate requests to the state for approval. This would make each insurance company run more efficiently, administer claims more efficiently and keep their operating costs down. This would be good for businesses in Florida as they would be able to shop in a competitive market, where no one is guaranteed a profit. Don't most businesses have to run this way?

We could start bringing truth to the process by making it unlawful for a carrier to require an employer or business owner to buy general liability coverage if they want to purchase the workers' compensation coverage. Carriers will underwrite the workers compensation policy at a lower than market rate to show they are losing money and will increase the cost of the general liability policy which will make up for any loss on the workers compensation policy, thus allowing them to "hide" the profitability of the workers' compensation insurance. It may be smart insurance business to do that but it costs the employers and businesses of Florida thousands of dollars every year.

If things are so bad for businesses in Florida because of these "problems," then why is it that the newest printed publication by our Chief Financial Officer, "Florida's Bottom Line" states that according to Dr. David Denslow, Professor and Research Economist at the University of Florida, and the Chief Executive Magazine, Florida is one of the five best states for business. By the way this publication probably costs more to print, publish and mail out than the Annual Report by the Division of Workers' Compensation which is on the chopping block.

Have our elected officials gone so far to appease the insurance industry that they are willing to allow insurance companies to make "EXCESS PROFITS"? Where will all this insanity end? Will the entire workers' compensation act have to be wiped out and we go back to 1934 when there were no workers' compensation laws in Florida. That would be very bad for business, it would be very bad for employees injured on the job and it would be terrible for Florida. The law requiring insurance companies to return to its policy holders "EXCESS PROFITS" has been in effect for over 32 years and has worked to save Florida businesses millions of dollars. Insurance companies were ordered to return over $200 million in the last 8 years alone. They did not do it voluntarily, they were ordered to do return these monies to Florida businesses. HB 4169 has been passed by the Florida House of Representatives but has not yet been taken up by the Florida Senate. It is unbelievable that our elected officials would allow insurance companies to collect Excess Profits. I urge everyone and every business owner to call or write your Florida Senators and tell them to vote against HB 4169. The Senate President is Mike Haridopolos. His phone number is 850-487-5628 and his email is haridopolos.mike.web@flsenate.gov. Immediately voice your opinion to him that this bill should not be allowed to pass.

Suggestions on How to Seek Review of Patently Unreasonable Fees after Kauffman

By Richard W. Ervin III, Esq., Tallahassee FL

As all of you know, as a result of the Supreme Court's opinion in *Murray v. Mariner Health*, 994 So. 2d 1051 (Fla. 2008), which decided that, because the 2003 amended version of section 440.34(1), Florida Statutes, was ambiguous in determining whether the fee schedule is the sole basis for awarding claimant's counsel a reasonable attorney's fee, the statute's pre-amendment discretionary factors would continue to be applied in determining what should be a reasonable fee, the Florida Legislature in 2009 amended all references in the statute to the term "reasonable" for the obvious purpose of removing any ambiguity. Under the current statute, not only are all carrier-paid fees limited to the amount provided in the fee schedule, but all fees, including those for which the claimant is also responsible, in that subsection (1) expressly states that the judge of compensation claims (JCC) shall not approve any fee in excess of the statutory fee formula.

.. . . the 2009 legislative changes to section 440.34(1), Florida Statutes, have removed any ambiguity that previously existed in the 2003 statute, and we now have a fee statute which, unlike the former, makes no pretense at being reasonable.

The validity of the legislative amendments has so far been upheld. On March 23, 2011, the First District Court of Appeal decided *Kauffman v. Cmty. Inclusions*, 57 So.3d 919 (Fla. 1st DCA 2011), rejecting all of appellant/claimant's constitutional and non-constitutional challenges pertaining to the application of the 2009 amended fee statute awarding a guideline fee in the total amount of $684.41 for the attorney's obtaining $3,417.03 in benefits, which computed to an hourly fee of $6.84, based on 100.3 hours expended by claimant's counsel. The fee amount was one that the JCC had no difficulty in concluding was unreasonable, and were it not for the fee schedule, he would have awarded a reasonable fee of $25,075.00, which equates to an hourly fee of $250.00.

The 2003 legislative amendments have had their effect during the past several years. As shown in the 2011-2011 Annual Report of the OJCC, the number of petitions for benefits filed has, among other things, markedly declined, from a high of over 151,000 in the fiscal year 2002-03 to 64,679, in 2010-11, or a reduction of 57%. The legislative changes have similarly affected the number of workers' compensation appeals, which peaked in 2003-04, with nearly 600, and have since steadily declined, reaching 337 filings in 2010-11.[1]

The 2003 and 2009 amendments to the attorney fee statute have also brought about substantial changes, as shown in the 2010-11 OJCC Annual Report. For example, in 2002-03, claimants' attorneys' fees were nearly on the same parity with carriers' fees, with claimants' attorneys receiving about $210,660,000, and E/Cs' fees being just over $220,000,000. In 2010-11, claimants' attorneys' fees had declined to approximately $157,000,000, while carrier's fees had risen to nearly $271 million. The claimants' attorney-fee aggregate for 2010-11 represents the 7th consecutive annual decline since 2003-04.

My own personal view is that the 2009 legislative changes to section 440.34(1), Florida Statutes, have removed any ambiguity that previously existed in the 2003 statute, and we now have a fee statute which, unlike the former, makes no pretense at being reasonable. I remain unconvinced by the *Kauffman* opinion, however, as to the constitutional issues, which the court considered were controlled by the court's prior opinions in *Campbell v. Aramark*, 933 So. 2d 1255 (Fla. 1st DCA 2006); *Lundy v. Four Seasons Ocean Grand Palm Beach*, 932 So. 2d 506 (Fla. 1st DCA 2006)); *Wood v. Florida Rock Industries*, 929 So. 2d 542 (Fla. 1st DCA 2006). *Kauffman* acknowledged that while *Murray* had disapproved the three above opinions in reaching its decision construing the statute as ambiguous, the *Kauffman* panel continued that because *Murray* had failed to address any constitutional issues, it did not as a result cast any doubt on the reasoning used by those three decisions in rejecting the constitutional claims before the court, which were similar to those raised in *Kauffman*. *Id.* at 921. I am not so sure.

While I agree that *Murray* expressly decided only the non-constitutional issue that the 2003 fee statute was ambiguously drafted, thereby causing the court to decide that the fee schedule was not the sole determinant for ascertaining the reasonableness of a fee award, there is other language in the opinion strongly indicating the court decided the case on such basis in order to avoid holding the statute unconstitutional. For example, it

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quoted *State v. Giorgetti*, 868 So.2d 512, 518 (Fla.2004), stating: "'We are also obligated to construe statutes in a manner that avoids a holding that a statute may be unconstitutional.'" *Id.* at 1053. The court otherwise stated it preferred to resolve the issues before it on the basis of statutory interpretation, "'so as to avoid an unconstitutional result'" *Id.* at 1057 (quoting *State v. Jefferson*, 758 So.2d 661, 664 (Fla. 2000). The clear import of the above statements is that if the court had interpreted the amended statute as it was written, it most likely would have determined it unconstitutional in its application to the facts which showed that the JCC's rigid adherence to the fee formula provided in section 440.34(1) yielded an hourly fee of only $8.11[2] to claimant's attorney at the carrier's expense

Another reason for questioning the *Kauffman* court's interpretation of the effect of the *Murray* decision is that only 28 days before *Murray* was decided, the supreme court issued its opinion in *Maas v. Olive*, 992 So. 2d 196 (Fla. 2008) (*Olive II*), which interpreted a somewhat similar statutory fee limitation as not precluding a trial court judge from exceeding the fee cap. The Supreme Court was asked in *Olive II* to decide whether section 27.7002 of the Registry Act, setting fee caps for the services of capital collateral representatives on behalf of death row inmates, was unconstitutional. The legislature, similar to its action in amending section 440.34 following the supreme court's decision in *Murray,* also amended section 27.7002 shortly after the supreme court decided *Olive v. Maas*, 811 So.2d 644, 654 (Fla.2002) (*Olive I*), which had held "trial courts are authorized to grant fees in excess of the statutory schedule where extraordinary or unusual circumstances exist in capital collateral cases." *Olive II*, in addressing the state's argument that the rationale of *Olive I* was no longer effective because the legislature had enacted section 27.7002 for the purpose of clarifying its intent that the fee caps could not be exceeded under any circumstances, answered:

> While this may have been the Legislature's intent, such an interpretation of the statute would render it unconstitutional. . . . [T]he decision in *Olive I* rests on the courts' inherent power to ensure adequate representation for death row inmates in postconviction challenges. "[The] courts have authority to do things that are absolutely essential to the performance of their judicial functions." *Rose v. Palm Beach County*, 361 So.2d 135, 137 (Fla.1978). This authority emanates from the courts' constitutional powers in the Florida Constitution. See art. II, § 3, Fla. Const. ("The powers of the state government shall be divided into legislative, executive and judicial branches. No person belonging to one branch shall exercise any powers appertaining to either of the other branches unless expressly provided therein."); art. V, § 1, Fla. Const. ("The judicial power shall be vested in a supreme court, district courts of appeal, circuit courts and county courts.").

Although it could be argued that the court's construction of the statutes under consideration in *Olive I* and *II* was based on the Sixth Amendment right to counsel in criminal cases, the court, in both those two cases, clearly rested its decision on the separation of powers provisions of Article II, section 3 of the Florida Constitution.

This distinction is important because nothing on the face of the court's opinions in the three prior cases discussed in *Kauffman*, *i.e.*, *Campbell v. Aramark*, *Lundy v. Four Seasons Ocean Grand Palm Beach*, or *Wood v. Florida Rock Industries*, specifically addressed a separation of powers challenge to the attorney-fee statute, as was involved in *Olive I* and *II*. Therefore, the rulings in those three cases had no binding, *stare decisis* effect on the court's decision in *Kauffman*. It is also important to note that the court's decisions in *Olive I and II* were strongly influenced by *Makemson v. Martin County*, 491 So.2d 1109 (Fla. 1986), and its progeny, in which the supreme court addressed the constitutionality of a statute that set fee caps on compensation provided to attorneys who represented defendants accused of crimes at trial and their appeals therefrom. Although the court did not there decide that the statute was facially unconstitutional, it concluded that it could be unconstitutional if it were applied in such a way as to curtail the court's inherent authority to ensure adequate representation of the criminally accused. *Id.* at 1112. The court concluded its analysis by stating:

> [W]e hold that it is within the inherent power of Florida's trial courts to allow, in extraordinary and unusual cases, departure from the statute's fee guidelines when necessary in order to ensure that an attorney who has served the public by defending the accused is not compensated in an amount which is confiscatory of his or her time, energy and talents.

Id. at 1115.

Although the courts' decisions in *Olive I* and *II* and *Makemson* involved the issue of the validity of fee caps for attorneys who represented criminal defendants, other judicial opinions following *Makemson* carefully pointed out that their decisions holding fee caps unconstitutional as applied to the particular circumstances before them were based on the separation of powers clause of the constitution. *See White v. Board of County Commissioners of Pinellas County*, 537 So.2d 1376, 1378 (Fla.1989), where the Florida Supreme Court held that an order which limited an attorney to the maximum statutory fee provided for representation of an indigent defendant in a capital case could be exceeded on the theory that the legislative fee cap was an unwarranted intrusion on the judiciary's inherent powers

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of the courts to appoint attorneys to such roles. In so deciding, the court approved the dissenting opinion of Judge Lehan in *White v. Board of County Commissioners of Pinellas County*, 524 So.2d 428, 431-432 (Fla. 2d DCA, 1988), which explained the constitutional basis for exceeding statutory fee caps in the following manner:

> Every court has inherent power to do all things that are reasonably necessary for the administration of justice within the scope of its jurisdiction, subject to valid existing laws and constitutional provisions. The doctrine of inherent judicial power as it relates to the practice of compelling the expenditure of funds by the executive and legislative branches of government has developed as a way of responding to inaction or inadequate action that amounts to a threat to the courts' ability to make effective their jurisdiction. The doctrine exists because it is crucial to the survival of the judiciary as an independent, functioning and co-equal branch of government. The invocation of the doctrine is most compelling when the judicial function at issue is the safeguarding of fundamental rights.

The inherent judicial doctrine has also been applied to parental termination and dependency cases. *See In the Interest of D.B.*, 385 So. 2d 83 (Fla. 1980), and *Board of County Com'rs of Hillsborough County v. Scruggs*, 545 So. 2d 910 (Fla. 2d DCA 1989). In *D.B.* and *Scruggs*, the courts observed that while there was no fundamental, constitutional right to counsel in dependency proceedings, the right to same might arise through the application of the Due Process of Law Clause, depending on the nature or complexity of the proceeding required by statute. In fact, a Minnesota Supreme Court opinion specifically recognized the applicability of the inherent judicial powers doctrine in a workers' compensation case where a statutory fee cap was exceeded. *See Irwin v. Sturdyk's Liquor*, 599 N.W. 2d 132 (Minn. 1999). The court noted that a finding had been made at the trial level, which it approved, that the statutory fees awarded failed to reasonably compensate claimant's attorney. As a result, the court, applying a separation of powers analysis, decided that the statutory fee cap was unconstitutional in its application, stating:

The doctrine of inherent judicial power as it relates to the practice of compelling the expenditure of funds by the executive and legislative branches of government has developed as a way of responding to inaction or inadequate action that amounts to a threat to the courts' ability to make effective their jurisdiction.

> Legislation that prohibits this court from deviating from the precise statutory amount of awardable attorney fees impinges on the judiciary's inherent power to oversee attorneys and attorney fees by depriving this court of a final, independent review of attorney fees. This legislative delegation of attorney fee regulation exclusively to the executive branch of government violates the doctrine of separation of powers. . . ." Accordingly, to the extent it impinges on our inherent power to oversee attorneys and attorney fees and deprives us of a final, independent review of attorney fees, we hold that section 176.081 is unconstitutional.

Id. at 142.

Similarly, the Florida Constitution assigns to the Florida Supreme Court the "exclusive jurisdiction to regulate the admission of persons to the practice of law. . . ." Art. V, _ 15, Fla. Const. It is also interesting to note that in reaching its decision, the Minnesota Supreme Court specifically referred to the *Makemson* decision, observing that while the Florida Supreme Court decided that the statutory maximums as applied interfered with the accused's Sixth Amendment right to counsel, it had also concluded that the statutory restrictions were "a violation of the Florida Constitution's separation of powers provision." *Id*.

Whatever was the Florida Supreme Court's intention in deciding *Murray,* the workers' compensation bar is now confronted with a decision of the First District Court of Appeal that is the last decisional statement by any court on the constitutionality of the current fee statute, and, despite the supreme court's discretionary authority to review decisions of district courts of appeal that declare valid state statutes, which was the constitutional foundation on which the *Murray* court accepted jurisdiction, the Supreme Court has, a little less than three years following its decision, for reasons known only to it, declined to exercise its power of review on such basis. One might well ask whether the legislative changes in 2009, which removed all references to the word "reasonable" in section 440.34, while possibly curing any prior ambiguity in the statute, have now resulted in a statute that is free from any potential constitutional infirmity, a lurking issue that the *Murray* court refused to expressly address in regard to the 2003 version for the purpose of "avoid[ing] an unconstitutional result."

The more immediate question by those attorneys who still continue to practice in the field of workers' compensation, and who may be affected by *Kauffman,* is what, if anything, can now be done? The answer is several things, but the least successful approach, in my opinion, would be in bringing another constitutional

challenge before the First District. The practical difficulty of pursuing a conventional appeal from a JCC's order which can't address constitutional issues and limits claimant's counsel to building a record before the JCC for the purpose of raising a constitutional challenge in the First District is that because, as a result of its decision in *Kauffman,* it is problematic whether the court would write, in a successive appeal involving the same issue, and instead might provide only a cite to *Kauffman,* which of course would not constitute a sufficient basis for the exercise of the supreme court's discretionary review. *See Dodi Pub. Co. v. Editorial America, S.A.*, 385 So. 2d 1369 (Fla. 1980).

I say this conditionally, however, because the track record of *Campbell v. Aramark*, *Lundy v. Four Seasons Ocean Grand Palm Beach*, *Wood v. Florida Rock Industries*, and *Murray v. Mariner Health* shows that before the supreme court accepted review jurisdiction over *Murray*, which occurred on October 30, 2007, it had already denied review of the three prior cases, despite the submission of certified questions of great public importance as to the fee statute's construction and the court's written opinions in those cases upholding the validity of the statute, both of which are grounds for the exercise of the supreme court's discretionary jurisdiction. While there is very little possibility that the First District Court will recede from its decision in *Kauffman*, it is conceivable that the First District might follow a similar path in cases following *Kauffman* as it did after *Wood, et al.,* by issuing a written opinion affirming and certifying a question of great public importance to the supreme court as to the 2009 fee statute's constitutionality.

If there is any practitioner out there who has a case that, by application of the fee formula in section 440.34(1), would result in a patently unreasonable hourly fee and, as a result, she or he decides to challenge the statute, I suggest that such attorney, if jurisdiction is located outside the First District, follow one of two alternative paths, thereby bypassing an appeal to that court.

The first is by directly filing a suit in circuit court for declaratory judgment. For example, in *Martinez v. Scanlan*, 582 So.2d 1167 (Fla. 1991), the facts recited that a final declaratory judgment of the circuit court was entered determining that various provisions of the 1989 and 1990 Workers' Compensation Law were unconstitutional, and the district court of appeal certified the case to the supreme court as being of great public importance and requiring immediate resolution. *See also Ortega v. Owens-Corning Fiberglas Corp.*, 409 So.2d 530, 531 (Fla. 1st DCA 1982), which reversed a circuit court's dismissal of a complaint for declaratory judgment that had declined to entertain constitutional challenges to the 1979 Workers' Compensation Law for the reason that such questions could be resolved by the district court of appeal "in the natural course" of the worker's claim for benefits. In reversing, the First District noted that the exhaustion of administrative remedies doctrine did not apply to workers' compensation cases involving constitutional issues.

In cases where an injured claimant seeks as the only basis for relief a determination that a particular statute is constitutionally invalid, facially or as applied, and does not couple with her or his action non-constitutional claims for benefits, a suit for declaratory judgment without prior resort to the JCC would appear to be an appropriate vehicle. The *Martinez* opinion provided some guidelines to be followed in pursuing this type of action. Although the court pointed out that the purpose of the declaratory judgment statute is to afford relief from insecurity and uncertainty with respect to a party's rights, status, and other equitable or legal relations, it cautioned that

> individuals seeking declaratory relief must show . . . there is a bona fide, actual, present practical need for the declaration; that the declaration should deal with a present, ascertained or ascertainable state of facts or present controversy as to a state of facts; that some immunity, power, privilege or right of the complaining party is dependent upon the facts or the law applicable to the facts; that there is some person or persons who have, or reasonably may have an actual, present, adverse and antagonistic interest in the subject matter, either in fact or law; that the antagonistic and adverse interest are all before the court by proper process or class representation and that the relief sought is not merely the giving of legal advice by the courts or the answer to questions propounded from curiosity.

Id. at 1170. The court concluded its discussion with the warning: "[T]here must be a bona fide need for such a declaration based on present, ascertainable facts or the court lacks jurisdiction to render declaratory relief." *Id.* The requirement that there be "a bona fide, actual, present practical need for the declaration" would appear to be clearly satisfied in cases where a determination is sought as to the validity of a contractual fee arrangement between a claimant and her or his attorney which exceeds the statutory limitations of section 440.34(1).

It is conceivable but not certain whether the procedure adopted by the Florida Supreme Court in *Key Haven Associated Enterprises, Inc. v. Board of Trustees of Internal Imp. Trust Fund*, 427 So.2d 153, 160 (Fla. 1982), could be applied to workers' compensation cases in which proceedings on the non-constitutional claims have first been brought before a JCC. The *Key Haven* decision allowed an aggrieved party the option of completing administrative review of a permit denial in

the executive branch, and, if the party did not further contest the validity of the denial by seeking district court of appeal review, she or he could then accept the agency's action and thereafter file suit in circuit court on the basis that the denial was proper, but it resulted in an unconstitutional taking of the party's property. As applied to workers' compensation cases, if a claimant's counsel were successful in obtaining benefits for the client, and it was then determined by the JCC that claimant was entitled to an attorney's fee at the employer/carrier's expense, but it appeared to counsel that any amount to be awarded would most likely be unreasonable under the statutory fee formula, it is submitted that claimant should then, at that juncture of the proceedings, have the option of seeking a declaratory judgment action in circuit court for a determination of the statute's validity – a decision that the JCC is not empowered to make.

It is important to emphasize that although the court's decision in *Key Haven* arose in the context of a permit denial by an administrative agency under chapter 120, Florida Statutes, and the applicant thereafter used the denial as the basis for its inverse condemnation suit in circuit court, the supreme court in *Key Haven* did not limit its decision solely to the facts before it, but it underscored the inherent lack of jurisdiction of a non-Article V tribunal to decide a constitutional question. It explained:

> A requirement that administrative proceedings be exhausted for the type of challenge presented . . . would be needlessly time-consuming and expensive. Since the facial constitutionality of a statute may not be decided in an administrative proceeding, . . ., this type of constitutional issue could not, absent recourse to the circuit courts, be addressed until the administrative process is concluded and the claim is before a district court of appeal on direct review of the agency action.

Key Haven, 427 So.2d at 157. It should be noted that the First District referred to the *Key Haven* procedure in *Anderson Columbia v. Brown*, 902 So. 2d 838, 841 (Fla. 1st DCA 2005), by commenting: "Claimant has every right . . . to build his record for appeal" in cases where "a JCC does not have jurisdiction to address the constitutionality of a statutory provision."

Chapter 440 is of course not identical to chapter 120, and workers' compensation adjudications are explicitly exempt from chapter 120. § 440.021, Fla. Stat. Nevertheless, neither an agency nor a JCC has the authority to determine the validity of a statute. It is suggested that virtually the same underlying policy goals approved by the supreme court in *Key Haven* as to administrative actions could be achieved by allowing an injured employee, if she or he is successful on the merits of a claim before a JCC and is thereafter awarded an attorney fee at the carrier's expense, to have the option of either appealing to the First District Court of Appeal the amount of fees awarded and raise there the issue of the validity of the fee authorized by the statutory formula, or, following a JCC's determination of entitlement, proceed directly to circuit court on the constitutional question. Perhaps the most important benefit of following a procedural path that diverges from invariable review by the First District Court of Appeal, in this limited area of the law, is that if a suit for declaratory judgment were filed in a circuit outside the jurisdiction of the First District, an appeal from the circuit court's order would then be brought before a different appellate court with a possible different and fresh perspective as to the constitutional issues raised.

A different approach seems to be essential to any meaningful review of the constitutional issues. It now appears to be extremely difficult to obtain discretionary review by the Florida Supreme Court. If an appellate court were to declare the fee statute invalid, mandatory review could be assured. Moreover, if the statute were declared unconstitutional, the immediate statutory predecessor in existence prior to the effective date of that determined invalid would be revived. *See B.H. v. State,* 645 So.2d 987, 995 (Fla. 1994)*; State ex rel. Boyd v. Green,* 355 So.2d 789 (Fla.1978)*; Henderson v. Antonacci,* 62 So.2d 5 (Fla.1952)*; Brister v. State,* 622 So.2d 552 (Fla. 3d DCA 1993) I remain confident that a court will at some time in the future so decide, most likely holding that the statute is unconstitutional in its application. In support of this conclusion, I offer the following example.

A different approach seems to be essential to any meaningful review of the constitutional issues. It now appears to be extremely difficult to obtain discretionary review by the Florida Supreme Court.

Assume the same facts as in *Kauffman*. A claimant prevails on her claims and is held entitled to a carrier-paid fee pursuant to the statutory fee formula in the amount of $684.41, based on benefits secured by counsel in the total sum of $3,417.03. Because, as found by the JCC, claimant's attorney reasonably spent 100.3 hours obtaining those benefits, the total fee awarded equates to an hourly fee of $6.84. The JCC also found, based on the complexity of the case and the difficulty of the issues, which required experience and skill on the part of the attorney in obtaining the award of benefits, that the amount required by the fee schedule was unreasonable. All of the above facts are supported by the record

in *Kauffman*; however, the panel's recital of them failed to inform the reader of the attorney's time involved, a factor which it apparently considered irrelevant to its decision.

Were I bringing in circuit court a constitutional challenge, as applied to the factual findings of the JCC, which the First District in *Kauffman* never stated were unsupported by competent, substantial evidence, I would stress the language in *Makemson* saying that a statutory fee cap should not be enforced if it has the effect of denying compensation to an attorney "in an amount which is confiscatory of his or her time, energy and talents." Moreover, I think it important to argue, as the *Makemson* court noted, that although the focus should be on a party's right to effective representation, rather than an attorney's right to fair compensation, the two are often inextricably linked. *Id.* at 1112. I would also not ignore the argument that if a substantial number of lawyers are forced to leave the workers' compensation field as a result of a rigid application of the fee schedule, the resulting alternative would require an ever increasing number of injured employees to handle their own claims.[3]

In this regard, although the Workers' Compensation Law was originally conceived as administrative legislation which would "be simple, expeditious, and inexpensive so that the injured employee, his family, or society generally, would be relieved of the economic stress resulting from work-connected injuries," *Lee Eng'g & Constr. Co. v. Fellows*, 209 So.2d 454, 456 (Fla. 1968), chapter 440, as it has since evolved, creates a labyrinthine maze of obstacles that makes it difficult, if not virtually impossible, for an unrepresented claimant to navigate. Among other things, the Law requires, if a managed care arrangement is in place, that all grievance procedures be exhausted before a petition for benefits may be filed, section 440.134(15)(a), Florida Statutes, and any petition filed must be sufficiently specific and detailed, requiring, among other things, "[t]he time period for which compensation was not timely provided[,] . . .[and] the [d]ate of maximum medical improvement, character of disability, and a specific statement of all benefits or compensation that the employee is seeking." 440.192(2)(e),(f). If a claimant's petition fails to comply with these provisions, it is subject to dismissal. 440.192(2).

Moreover, if the cause of an injury were contested, the claimant would need to prove that the employment was more than 50 percent responsible for the injury, as compared to all other causes combined. 440.09(1). If the unrepresented worker was able to overcome that hurdle, he or she most likely would be confronted with the employer's apportionment defense, as provided in section 440.15(5)(b), the validity of which is currently uncertain. Finally, an injured employee would need to have more than a cursory knowledge of the law pertinent to occupational disease and exposure cases, particularly in light of recent amendments. The above list of statutory provisions is of course not all inclusive, but they are representative of the complexity to which the Law has developed over the past 20 years.

It should be abundantly clear from the above statutory references that an unrepresented employee could not reasonably be expected to prevail on a claim when pitted against an experienced adversary defending an employer/carrier. As the First District has previously observed: "Without the assistance of competent counsel, claimant would . . . have been 'helpless as a turtle on its back.'" *Davis v. Keeto, Inc.*, 463 So.2d 368, 371 (Fla. 1st DCA, 1985), quoting *Neylon v. Ford Motor Company*, 27 N.J.Super. 511, 99 A.2d 665 (1953).

It is presumed that the legislature, in creating the workers' compensation system, did not do so with the intention of providing injured workers with only an illusory right to compensation benefits. It has, however, established such a complex procedure for processing claims that it would be unreasonable to assume that the worker without the assistance of experienced counsel could realistically expect to achieve success. *In the Interest of D.B.*, 385 So. 2d 83, 89 (Fla. 1980), the Florida Supreme Court commented on the right to counsel in dependency proceedings, saying that such right "is governed by due process considerations, rather than the sixth amendment. The extent of procedural due process protections varies with the character of the interest and nature of the proceeding involved." While a claimant may have no fundamental right to the assistance of counsel in prosecuting a workers' compensation claim, the nature of the proceeding involved may be such that without the assistance of an attorney, she or he would have no reasonable prospect of succeeding, thereby denying the injured employee the right to procedural due process.

Section 440.34, as currently written, does not confine its limitations only to cases in which claimants prevail, but extends them as well to any fee retainer entered into between the claimant and her or his counsel. For example, section 440.34(1) provides: "The retainer agreement as to fees and costs may not be for compensation in excess of the amount allowed under this subsection or subsection (7)."[4] Thus, if an attorney attempted to enter into an agreement with the client for a prospective fee more than the statutory amount, which, in the *Kauffman* case, resulted in an hourly fee of $6.84, the attorney could be subjected to the criminal sanction of a first-degree misdemeanor, as provided in section 440.105(3)(c).

It is respectfully submitted that a statute which sub-

• ***Patently Unreasonable Fees***

jects a claimant's counsel to a mandatory fee of no more than $6.84 per hour, regardless of whether the client is the prevailing party in claims litigation or agrees to the payment of a fee exceeding the guideline amount, can hardly be said to comport with any standard of reasonableness. Frankly, if the rule in *Makemson* and its progeny has any applicability to workers' compensation proceedings, it appears that such a fee must be considered confiscatory of the lawyer's time, energy and talents, and for that reason the statutory schedule as it presently exists in section 440.34(1), Florida Statutes, should be considered a violation of Florida's separation of powers provision as applied to the facts. The problem now is in finding a court that will agree.

Richard W. Ervin, III, *of counsel with Fox & Loquasto, P.A., in Tallahassee, began his association with the firm in September 2007. His areas of practice are appellate and alternative dispute resolution (he is certified as a circuit civil mediator). He is a former judge of the First District Court of Appeal, and served in that capacity from January 1977, until his retirement in January 2007. From 1983 1985, he occupied the position of chief judge of that court. During his service as a judge, he wrote hundreds of judicial opinions for the court and participated in far more cases in the panels to which he was assigned. He also served as Public Defender, Second Judicial Circuit, from 1963 1977, and in such capacity he established the first appellate division in that system, and was responsible for filing numerous briefs in both the First District Court of Appeal and the Florida Supreme Court. In 2008, he associated with Susan Fox in the preparation of an amicus curiae brief in Murray v. Mariner Health, 994 So. 2d 1051 (Fla. 2008), on behalf of Voices, Inc., in support of Petitioner's position. He received his B.A. degree from Florida State University in 1957, and the same year was admitted to the Phi Beta Kappa scholastic honorary fraternity. Upon his graduation from the College of Law, University of Florida, in 1960, where he obtained his J.D. degree, he served as an assistant United States attorney for the Northern District of Florida, from 1960 1962, and engaged in the private practice of civil law from 1963 1969. In addition to his membership in the Florida Bar, Ervin has been a member of the Tallahassee Bar Association, the Florida Conference of District Court of Appeal Judges, and was admitted to practice before the United States Supreme Court, the Court of Appeals, Fifth Circuit, and the United States District Court for the Northern District of Florida. In 2007, he received the Florida Justice Association's Judicial Award, and in 2010, he was recognized as a 50-year member of the Florida Bar.*

Endnotes:

1 *See* caseload statistics of Clerk of First District Court of Appeal.

2 A judge of compensation claims, of course, lacks the authority to decide any constitutional issues raised. *See Anderson Columbia v. Brown*, 902 So. 2d 838, 841(Fla. 1st DCA 2005).

3 As of yet, however, the volume of self-represented claimants is not increasing, but rather the reverse. The 2010-11 Annual OJCC Report shows that in fiscal year 2010-11, 10.85% of the new cases filed were pro se, as compared with 21.94% in 2002-03. In fact, there has been a steady decrease in pro se filings every year since 2002-03.

4 Section 440.34(7), Florida Statutes, prohibits the payment of a fee more than $1,500 per accident for prevailing on a medical benefits only claim.

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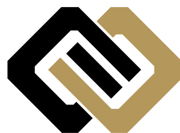

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Petitions for Rule Nisi Under Section 440.24

By Thomas P. Vecchio, Esq., Lakeland, FL

Orders issued by JCCs usually have their intended effect. The party that is compelled to act pursuant to an order generally seeks to satisfy the terms of the order as quickly as possible. This is true with respect to discovery and interim proceedings, as well as final orders following a merits hearing. No claimant, employer/carrier representative, or attorney representing either of them wants to stand before the Judge in order to explain why he or she failed to comply with an order.

Circumstances occasionally arise, however, where a party fails to comply with an order. A JCC does not have inherent jurisdiction to enforce his or her orders. Even so, claimants and employer/carriers often petition the JCC for an order that will hopefully prompt compliance from the other side. When such efforts to enforce compliance with a final order have been exhausted, an injured worker (but not an employer/carrier) has the option of filing a petition for rule nisi in circuit court.

Section 440.24(1), *Florida Statutes*, provides that:

> In case of default by the employer or carrier in the payment of compensation due under any compensation order of a judge of compensation claims or other failure by the employer or carrier to comply with such order within 10 days after the order becomes final, any circuit court of this state within the jurisdiction of which the employer or carrier resides or transacts business shall, upon application by the department or any beneficiary under such order, have jurisdiction to issue a rule nisi directing such employer or carrier to show cause why a writ of execution, or other such process as may be necessary to enforce the terms of such order, shall not be issued, and, unless such cause is shown, the court shall have jurisdiction to issue a writ of execution or such other process or final order as may be necessary to enforce the terms of such order of the judge of compensation claims.

Section 440.24(2), *Florida Statutes*, sets forth the mechanism through which a carrier's license can be suspended based on failure to comply with the circuit court's writ of execution. The following section addresses the manner by which a self-insured employer loses its right to maintain self-insured status, based on failure to comply with the circuit court writ of execution.

Section 440.24(4), *Florida Statutes*, is the only portion of the rule nisi statute that addresses an injured worker's failure to comply with a JCC's order. Where an injured worker does not comply with a JCC's order, the JCC can dismiss pending claims or suspend compensation benefits until the claimant complies. The statute is silent, however, with respect to an employer/carrier's ability to use circuit court rule nisi proceedings to force a claimant's compliance with a JCC's order. An employer/carrier has no statutory authority to petition the circuit court for rule nisi relief when the claimant fails to comply with a compensation order.

Thus, petitions for rule nisi are truly a one way street: claimants may use rule nisi proceedings to force employer/carrier compliance with a JCC's order, but the employer/carrier does not have a reciprocal right when the claimant fails to comply with the JCC's order.

The moment attorneys appearing before a circuit court judge utter the words "workers' compensation," the initial reaction from the judge is usually a question as to why the parties are now before him or her. Educating the circuit court of rule nisi enforcement proceedings is often an essential task prior to arguing the merits and defenses of the motion. A variety of cases have been determined throughout the years dealing with rule nisi relief, which will be summarized below. Please note, however, that these cases arise from the various District Courts of Appeal, rather than the First DCA alone. This raises a potential appellate issue not frequently seen in workers' compensation cases, to wit, conflict jurisdiction.

Petitions for rule nisi are truly a one way street: claimants may use rule nisi proceedings to force employer/carrier compliance with a JCC's order, but the employer/carrier does not have a reciprocal right when the claimant fails to comply with the JCC's order.

There is not a plethora of appellate cases addressing petitions for rule nisi pursuant to Sec. 440.24. The legal analysis is limited based on the limitations of rule nisi jurisdiction.

Jurisdiction

The Third DCA set forth a basic standard for the circuit court's inquiry upon consideration of a petition for rule nisi. In *Alvarez v. Kendall Associates,* 590 So. 2d 518 (Fla. 3d DCA 1992), the JCC awarded attendant care benefits which the employer/carrier did not provide. The claimant filed a petition for rule nisi, whereupon the circuit court awarded a monetary judgment in the Claimant's behalf equal to the costs of attendant care benefits during the timeframe where the employer/

• *Petitions for Rule Nisi*

carrier did not comply with the compensation order.

The employer/carrier filed a motion for rehearing, and argued that the circuit court exceeded the bounds of rule nisi jurisdiction in awarding a monetary judgment. The circuit court therefore vacated its first order and remanded the case to the Judge of Compensation Claims for determination of "an equitable remedy."

The Third DCA held that this was improper. The Court noted that the circuit court judge exceeded the bounds of rule nisi jurisdiction by evaluating the merits of the underlying compensation order. The circuit court's responsibilities were limited to determining whether the subject order was still in full force and effect, and upon concluding that it was, simple enforcement of its provisions. This case cites a litany of older cases regarding the scope of rule nisi jurisdiction.

The circuit court's inquiry upon consideration of a rule nisi petition is limited. Specifically, the court is charged with undertaking a two-pronged inquiry, first determining whether there is a final order in full force and effect, and then determining whether there has been a default under that order. It is improper to use rule nisi proceedings to consider or evaluate the merits of the underlying compensation order, or to resolve factual disputes that were properly the subject of the compensation hearing. *City of Hollywood v. Benoit*, 1 So. 3d 1142 (Fla. 4th DCA 2009).

In this action, the court first noted that, "logic and reasoning are constrained by strict procedural limitations in this appeal." The court then elaborated upon the absurdity imposed upon this case by strict interpretation of Section 440.24.

The claimant sustained a severe head injury in the course and scope of his employment. The parties entered a stipulation wherein they agreed that the employer/carrier would pay the claimant's mother for providing attendant care benefits for 12 hours per day, every day, at the federal minimum wage. The claimant was subsequently transferred from his home to an in-patient facility, whereupon his mother stopped providing attendant care. The employer/carrier then discontinued payment of attendant care benefits. The claimant filed a petition for rule nisi seeking payment of the attendant care to his mother, per the prior stipulation that was approved through an order.

The Fourth DCA noted that the circuit court's inquiry was limited to the two-pronged analysis set forth above. In applying the legal standard to the facts of this case, the employer/carrier had indeed defaulted pursuant to the prior order and was therefore responsible for paying attendant care to the claimant's mother for an 18-month period when she was providing no attendant care on her son's behalf. The court noted that consideration of the merits of the claim was beyond the scope of the circuit court's limited jurisdiction. The Fourth DCA held that the, "change in circumstances is a factual issue which only the JCC has jurisdiction to decide. A rule nisi proceeding is not a forum for taking evidence as to whether the mother is fulfilling her obligation under the stipulation." The employer/carrier should have sought modification of the prior order, despite the obvious windfall the claimant would receive through payment of attendant care benefits to his mother at a time when he was living in a nursing home.

A change in the underlying facts upon which the compensation order is based does not allow the employer/carrier to unilaterally alter the provision of benefits. The employer/carrier must seek modification of the order awarding benefits. In *Frank v. Crawford and Company,* 670 So. 2d 117 (Fla. 4th DCA 1996), the claimant was awarded attendant care after a compensable knee injury. The evidence showed that the claimant had two very young children. Her injury rendered her unable to safely care for her children. The JCC therefore awarded attendant care benefits on the claimant's behalf.

The employer/carrier suspended attendant care benefits based on the claimant's physician determining that the claimant did not need ongoing attendant care. After this unilateral suspension of benefits, the claimant filed her petition for rule nisi.

The Third DCA held that the employer/carrier remained bound by the order awarding attendant care benefits, even though the treating physician determined that the claimant no longer required attendant care. The court noted the limited scope of jurisdiction with rule nisi proceedings before the circuit court, comprised of determining whether or not the underlying compensation order remains outstanding, and if so, simple enforcement of its provisions. The court noted that the employer/carrier was obligated to seek modification of the first order awarding attendant care prior to discontinuation of those benefits. This is similar to the circumstances in *City of Hollywood v. Benoit*, *supra*, where the Fourth DCA noted that applicability of the law may result in, "a battle between common sense and the procedural limitations of a writ of rule nisi."

The Fifth DCA discussed the circuit court's limited rule nisi jurisdiction in *Merritt v. Promo Graphics, Inc.*, 691 So. 2d 632 (Fla. 5th DCA 1997). In this case, the JCC awarded PTD benefits on the claimant's behalf. The employer/carrier appealed this decision, but the compensation award was affirmed.

When the employer/carrier began paying PTD benefits, the Social Security disability offset was applied, thereby reducing the claimant's bi-weekly PTD payments. The claimant filed a petition for rule nisi, setting forth the argument that the underlying compensation order made no reference to the Social Security disability offset. The claimant argued that because the underlying compensation order made no mention of the SSD offset, the employer/carrier was prohibited from applying the offset to his PTD benefits.

The Fifth DCA denied the claimant's petition for rule nisi on the grounds that the SSD offset may be taken unilaterally by the employer/carrier as an administrative matter, without the JCC's intervention. Since both Florida and federal law allow for the SSD offset, the

employer/carrier was not required to secure language in a compensation order entitling it to the offset to which it was entitled as a matter of law.

The claimant next argued that the employer/carrier improperly calculated and applied the SSD offset on a retroactive basis. The Fifth DCA held that this was a legal and factual dispute which it did not have jurisdiction to entertain. This was a matter that the JCC must decide. The court noted that rule nisi, "is not to be used to determine the merits of the underlying compensation order or to resolve factual disputes between the parties." The circuit court's jurisdictional reach is limited to determining whether there is an outstanding final order in full force and effect, and if so, whether there has been a default under that order.

See also, *Sarakoff v. Broward County School Board*, 736 So. 2d 1232 (Fla. 4th DCA), where the court allowed the employer/carrier's unilateral and administrative offset of wages and unemployment which the claimant received during the period of entitlement ordered by the JCC.

The circuit court is prohibited from consideration of issues that were raised, or should have been raised, before the JCC. *Gruber v. Caremark, Inc.,* 853 So. 2d 540 (Fla. 5th DCA 2003). In this case, the employer was insured by an out-of-state carrier which had been placed into rehabilitation. A state court in Pennsylvania ruled that all pending claims affecting the interests of the carrier were stayed during the rehabilitation. The Fifth DCA noted that in the interests of comity, a Florida court would be obliged to abide by the terms of the order entered in Pennsylvania.

Without raising the carrier's rehabilitation and stay as a defense, the employer and its servicing agent (but not the carrier) entered a stipulation to pay an attorney's fee to claimant's counsel. An order was entered approving the stipulation, but the fees were not paid. The claimant filed a petition for rule nisi, demanding payment pursuant to the order approving the fee stipulation. Despite the fact that all proceedings against the carrier were stayed, the employer/servicing agent never claimed the benefit of the stay before the JCC. The Fifth DCA therefore determined that the employer and the servicing agent waived the effect of the stay, and entered an order for payment of attorney's fees. The employer/servicing agent failed to raise the defense pertaining to the stay and rehabilitation before the JCC, and could not use the stay to avoid compliance with the order compelling payment of stipulated attorney's fees.

The First DCA addressed the complete division of jurisdictional duties between the JCC and the circuit court in *Metropolitan Dade County v. Rolle*, 661 So. 2d 124 (Fla. 1st DCA 1995). The claimant in this case was awarded attendant care benefits pursuant to a compensation order. The employer/carrier initially paid attendant care benefits, but unilaterally reduced attendant care based on its determination that the claimant did not require, nor was entitled to, the full attendant care benefits ordered by the JCC. The claimant filed a petition for rule nisi based on the employer/carrier's failure to comply with the compensation order.

The circuit court did not enforce the compensation rder, but ordered the claimant to secure a determination from the JCC quantifying the value of the attendant care services in arrears. The claimant then filed a motion asking the JCC to determine the amount of attendant care owed. The JCC granted the claimant's request, and entered an order setting forth the dollar value of attendant care benefits which were owed to the claimant, but which the employer/carrier did not pay.

The First DCA held that the circuit court could not "remand" this task to the JCC, or call upon the JCC to serve as a fact-finder for purposes of enforcement of the order. The circuit court was entitled to hold an evidentiary hearing in order to calculate the value of benefits due to the claimant pursuant to the compensation order. The circuit court was not at liberty, however, to charge the JCC with the responsibility of calculating benefits due pursuant to a compensation order. The JCC was without jurisdiction to calculate attendant care benefits due to the claimant (ostensibly based on the absence of a claim requesting same) and the circuit court was without jurisdiction to place the matter back before the compensation court for purposes of securing a finding of fact. "Nothing in the clear terms of Subsection 440.24(1), authorizes the circuit court to relinquish jurisdiction to the judge of compensation claims to act, in effect, as a special master to make findings of fact as to the amount of benefits due the claimant."

Order Must Be Final

A recent opinion from the Second DCA addressed the distinction between final orders, which are proper for rule nisi enforcement proceedings, and non-final orders which are not. *King v. Parker Hannifin Corp*., 17 So. 3d 785 (Fla. 2d DCA 2009). The dispute in this case centered on finality of the order for which the claimant sought circuit court rule nisi enforcement.

The claimant had a compensable injury for which the employer/carrier provided benefits for many years. The parties proceeded to mediation at a time when three petitions for benefits were outstanding. The employer/carrier agreed to provide the claimant with medical care and treatment. This disposed of one PFB. The second PFB remained outstanding, and the claimant withdrew the third.

When the employer/carrier delayed provision of medical care and treatment, the claimant filed a petition for rule nisi. After the petition for rule nisi was filed, the employer/carrier provided the indicated medical care, but the claimant continued with proceedings related to the petition for rule nisi for purposes of a fee claim.

The employer/carrier argued that the petition for rule nisi addressed a non-final order, that the workers' compensation claim remained open and active, and that the circuit court therefore did not have jurisdiction. The circuit court judge agreed, and dismissed the petition

• *Petitions for Rule Nisi*

for rule nisi.

The claimant appealed to the Second DCA on the grounds that the order addressing the medical claims was indeed final, and that all claims ripe for adjudication with respect to that order had been resolved. The Second DCA agreed that there were unresolved claims before the JCC, and that the workers' compensation claim was still being litigated. The court drew a distinction, however, between final orders and interlocutory orders. The court noted that JCCs retain the power to enforce interlocutory orders through striking claims and defenses, but do not have authority to enforce final orders.

In this case, the order approving the mediation agreement was final with respect to the medical claims addressed therein. This order was therefore subject to rule nisi enforcement. Although provision of medical care and treatment was rendered moot by the time the Second DCA entered its order, the case was remanded to the circuit court to address attorney's fees and costs owed to the claimant for successful prosecution of the petition for rule nisi.

This case contains a detailed discussion regarding final and non-final orders, and what types of orders are subject to rule nisi enforcement. One of the court's conclusions was that orders compelling provision of medical care and treatment are final, but orders awarding IMEs are not, and are therefore not subject to rule nisi enforcement.

A claimant may file a petition for rule nisi only after the compensation order becomes final. In *Mabire v. St. Paul Guardian Insurance Co.,* 946 So. 2d 40 (Fla. 1st DCA 2006), the JCC entered an order compelling the employer/carrier to complete construction of an exercise pool at the claimant's home. The compensation order indicated, however, that jurisdiction was reserved over all issues until the construction project was completed.

The claimant filed a petition for rule nisi, seeking relief from the circuit court in enforcing the compensation order. The employer/carrier argued that the order was not final because the JCC reserved jurisdiction "over all issues" until the construction project was completed. The claimant argued that the compensation order was never appealed, and was therefore final and enforceable by the circuit court.

The First DCA initially noted that JCCs have no inherent authority to enforce their own final orders. In this case, however, the compensation order was final because all claims ripe for adjudication had been addressed and disposed of. The claimant was therefore at liberty to seek rule nisi relief.

Rule Nisi Relief Available Only To Claimants

Two recent cases have confirmed that rule nisi is an avenue of relief available to claimants, but not employer/carriers. *See, Brown v. Clay County Board of County Commissioners,* 43 So. 3d 782 (Fla. 1st DCA 2010), *and Orange County v. New*, 39 So. 3d 423 (Fla. 5th DCA 2010).

In these cases, the employer/carrier sought rule nisi relief in order to compel the claimant to reimburse costs. Both courts held that rules of statutory construction did not cause them to interpret Section 440.24 to apply equally to injured workers and claimants. The statute is clear and unambiguous, and it is "entirely plausible" that the legislature drafted the rule nisi statute to provide this form of relief only to injured workers. Until the recent advent of an employer/carrier's ability to secure reimbursement of costs from injured workers, there were no types of final orders that compelled claimants to act to the benefit of employer/carriers. Thus, it was reasonable to conclude that the statute addressing rule nisi relief was designed to afford claimants an avenue of recourse that is not available to employer/carriers.

Attorney's Fees

The circuit court judge has jurisdiction to award attorney's fees in rule nisi proceedings pursuant to the authority of Sections 440.34 and 440.24(1). *Transportation Casualty Insurance Co. v. Feldman*, 927 So. 2d 947 (Fla. 3d DCA 2006). This Court held that general portions of the insurance statutes which allow insureds an award of attorney's fees upon successful suit against their insurers do not apply to workers' compensation claims. The more specific provisions of Sections 440.24 and 440.34 govern.

Conclusion

Since Judges of Compensation Claims have no inherent authority to enforce their final orders, petitions for rule nisi are available to injured workers to secure the employer/carrier's compliance with a compensation order. The employer/carrier, however, has no equivalent right. Sec. 440.24, *Florida Statutes,* does not allow an employer/carrier to file a petition for rule nisi against a claimant who fails to comply with an order.

The order the claimant seeks to enforce must be final, and in full force and effect. The claimant must prove that the employer/carrier did not fully comply with the plain terms of the order for the circuit court to properly exercise rule nisi jurisdiction. An attorney representing an injured worker is entitled to fees and costs at the employer/carrier's expense for successful prosecution of a petition for rule nisi, which are adjudicated by the circuit court.

Thomas P. Vecchio *is the senior partner of Vecchio, Carrier & Feldman, P. A. of Lakeland. He is a 1992 graduate of Stetson University College of Law. He was Board Certified in workers' compensation in 2002.*

Hidden Dangers of WC Denials and ERISA Group Health Subrogation Claims

By Nancy Cavey, Esq., St. Petersburg, FL

Introduction

Workers' compensation adjusters regularly make claims decisions about the compensability of an industrial accident, medical causation and medical necessity of treatment. These decisions may ultimately result in an ERISA reimbursement and/or subrogation claim by a group health care provider who has paid for the medical treatment denied by the workers' compensation carrier.

Workers' compensation claimants are often provided group health care benefits through their employer. With the exception of group health care provided by church plans and municipalities, most disputes about the payment of group benefits is governed by the Employment Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1001, et. seq., 29 U.S.C. Section 1003(a).

Did you know that many group health insurance policies have terms that allow the insurance plan or carrier to recover benefits that have been "overpaid" or paid by another party to the policy holder? The Employer/Carrier's Notice of Denial is the green light for a workers' compensation claimant with group health insurance to obtain that medical treatment under the auspices of their group plan. The savvy workers' compensation claimant attorney should file a Petition for Benefits seeking the payment of that denied care to protect the interests of the claimant and be prepared to address the group carrier's lien as part of the settlement. And, it should not come to the surprise of the Employer/Carrier that ERISA reimbursement and/or subrogation claim will raise its ugly head.

Health Insurance Claims

There are no uniform ERISA Group health care policies. Each is different and the claimant should obtain a copy of the policy from the employer. ERISA regulations require this document be produced and can be subject to a daily fine for the failure to do so. Group health insurance plans will generally pay the medical expenses of the workers' compensation policyholder if the claimant suffers an injury caused by a third party or through no fault of their own. Some policies will exclude payment if the injuries are caused by a workers' compensation injury. But the filing of a Notice of Denial by the Employer/Carrier can overcome these policy terms and result in the provision of medical treatment. When the injured worker later settles the workers' compensation case, the group health plan or carrier can, and most likely will, claim that the workers' compensation carriers should have paid the medical expenses and is entitled to recover from the workers' compensation settlement all the money paid for the medical expenses. If the claimant and/or the workers' compensation attorney do not pay the group health care back, the group health care provider can sue both under ERISA.

Reimbursement and Subrogation

Most group health policies will have both a reimbursement and subrogation clause which obligates the injured worker to notify the group health carrier of any proposed settlement, secure their approval before finalizing any settlement and to protect their interests. But what happens if the claimant does none of those things or, worse yet, does not pay back the group health carrier or plan? The U.S. Supreme Court addressed what civil remedies are available to a group health carriers in *Great-West Life & Annuity Ins. Co. v. Knudsen*, 534 U.S. 204, 122 S.Ct. 708, 151 L.Ed 2d 635(2002). Under ERISA, the only cause of action available is an ERISA Section 502(a)(3) claim which provides for "equitable remedies."

In *Sereboff v. Mid-Atlantic Services*, 126 U.S. 1869 (2006), the Supreme Court took a second look at Knudsen. The court explained that equity only provided certain remedies when specific assets, like settlement proceeds, could be traced back to specific funds did not provide a complete list of all the equitable remedies available. While the Supreme Court did not explicitly recede from *Knudsen*, the practical result is that the plan administrator or ERISA fiduciary can recover money from a plan beneficiary to enforce the terms of the plan even if the plan can't trace the specific funds into the beneficiaries hands. However, if the settlement funds are placed in a trust fund, which is not likely in a workers' compensation settlement, the group health carrier can't recover those funds without establishing a constructive trust over the funds.

Sereboff also holds that equitable claims by the ERISA plan are NOT subject to equitable defenses. *Serboff* stands for the proposition that a group health care plan or carrier can enforce the terms of the group health plan or policy and has an equitable claim. That claim can involve not only the workers' compensation claimant/ policy holder, the workers' compensation carrier but the claimant and the defense attorney. While it is beyond the scope of this article to speak to the ethically requirements of both the claimant and the defense attorney in this situation, I would suggest both have ethical duties that must be considered.

Real Life Headaches and Malpractice Traps

Let's take an example of just what might happen in a workers' compensation case when the Employer/Carrier denies the compensability of an accident or denies treatment and the claimant obtains that treatment under the auspices of the group health insurance. The claimant will provide the group carrier with the Notice of Denial and the group carrier will typically remind the claimant of the carrier's right to subrogation or reimbursement.

This issue disappears until it is brought up just before or at mediation where, unfortunately, it can become a headache and a malpractice trap. Some lawyers, both claimant and defense, will attempt to hide behind the infamous Sargent Shutlz defense of "I know nothing at all, nothing at all!" Or, better yet, "It is not my problem or my client's problem!"

It is a problem and, increasingly in my ERISA practice, I am hired to clean up the subrogation mess, recommend civil litigation to enforce mediation agreements, and worse yet, recommend, once the dust has settled, malpractice litigation against both the claimant and defense attorneys. Let me give you a real life example. The claimant's attorney enters into a settlement agreement with the carrier and, as part of that agreement, the Employer/Carrier agrees they will "defend, indemnify and hold harmless from any and all liens, claim of liens, subrgoation or any claims the group health carrier has or may have in the future." The Employer/Carrier had good reason to settle the case and address the lien based on their exposure. That is not the issue! Neither attorneys bothered to obtain and read the group health plan before the mediation. Had they done so, they would have learned the plan required:

- Notice of the settlement,
- Approval of the settlement by the group carrier,
- Provision that the third party, who pays the settlement (the workers' compensation carrier) stands in the shoes of the claimant and has an obligation to protect the group health carrier,
- Provisions regarding the payment of the group health carrier's attorney fees for failure to protect

Photo from a February 3, 2012 luncheon hosted by Judge Renee Hill of Gainesville.

From left to right are: **Jack A. Langdon, Esq.,** Past President (1977-78) of the Eighth Judicial Circuit Bar Association, former Workers' Compensation Executive Council Member, and former Board Certified Workers' Compensation Lawyer (from the initial exam); **Hon. Marjorie Renee Hill,** Judge of Compensation Claims, Gainesville District; **Mac McCarty, Esq.,** current Eighth Judicial Circuit Bar Association President, former Workers' Compensation Executive Council Member, and former Board Certified Workers' Compensation Lawyer (from the second exam); and **Stuart, Suskin, Esq.**, State Workers' Compensation Mediator, Gainesville District.

the group health carrier's interests.

Neither attorney has advised the group carrier of the settlement or obtained approval of the settlement by the group carrier. Yet, the Employer/Carrier has now filed a Motion to Enforce a Settlement agreement. That is a very interesting approach!

How to Properly Handle an ERISA Group Health Care Issue

Here are some very basic suggestions:

- Both parties must determine if there is a group health care lien. If the claimant used his group health coverage to get medical treatment, count on it!
- Both parties must get the group health care plan and read it! What does it say about subrogation and reimbursement? What are the duties of the claimant and what are the legal obligations of the worker's compensation carrier? Do you need notice or approval?
- Properly value the case, including the health care lien.
- Make sure all parties have enough time to comply with the group health care claims and notice process.
- Make sure your mediation agreement tracks the group health care language and addresses all possible contingencies, including the group health carrier's refusal to resolve the lien favorable, payment of attorney fees for the resolution of this issue and enforcement of any mediation agreement if the resolution of the lien fails.

Conclusion

Handling an ERISA group health care lien issue is an integral part of the resolution of any worker's compensation claim and the failure to do so can result in both a poor outcome for the claimant and a possible malpractice.

Don't be afraid to reach out for help before you make a costly mistake!

Nancy L. Cavey*, born in Baltimore, Maryland was profoundly affected when her father, co-owner of an insurance brokerage company, became disabled. She learned firsthand of the devastating physical and financial consequences of disability and brings these insights to her practice as she aggressively fights for disability benefits due her clients. Ms. Cavey received her BA with highest honors from Hamline University with distinction in American Studies. She is a 1980 graduate of the William Mitchell College of law in St. Paul, Minnesota. Nancy Cavey is former Chair of the Workers' Compensation Section of the Florida Bar and concentrates her practice in Workers' Compensation and representing claimants in Long Term Disability / ERISA claims. Ms. Cavey is AV rated by Martindale Hubbell, their highest rating. She is licensed to practice in Florida and in the United States District Court for the Northern and Middle Districts.*

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Medicare Secondary Payer Mandatory Reporting Provisions in
Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)
(See 42 U.S.C. 1395y(b)(7)&(b)(8))

ALERT

Revised Implementation Timeline for Certain Liability Insurance (Including Self-Insurance) Total Payment Obligation to the Claimant (TPOC) Settlements, Judgments, Awards or Other Payments

The Centers for Medicare & Medicaid Services (CMS) has delayed Section 111 reporting for certain liability insurance (including self-insurance) TPOC settlements, judgments, awards, or other payments. The implementation date for reporting will be based on the TPOC amount. Below is a schedule of the new dates.

TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over $100,000	October 1, 2011	January 1, 2012
TPOCs over $50,000	April 1, 2012	July 1, 2012
TPOCs over $25,000	July 1, 2012	October 1, 2012
All TPOCs over min. threshold	October 1, 2012	January 1, 2013

The CMS has not changed any other MMSEA Section 111 implementation dates. See the applicable MMSEA Section 111 User Guide. In addition, other relevant information, including explanations of TPOC, ORM, and a Responsible Reporting Entity, can be found in the User Guide. (Note: This delay is optional).

The content of this ALERT supersedes the content of the existing User Guide (Version 3.2) and will be incorporated into the next version of the User Guide. After full implementation of the Section 111 reporting requirements, CMS will use the normal notice of proposed rulemaking process for establishing any penalties.

Invoking "the Rule" During Depositions? Absolutely "Maybe"

By Bryan R. Rendzio, Jacksonville, FL

"Your Honor, I'd like to go ahead and invoke 'the rule.'" Most litigators have uttered these words during a trial, or conversely, heard the phrase come from the direction of opposing counsel's table. There comes little astonishment when the expression is conveyed within the confines of the courthouse walls. When someone mentions invoking "the rule" during a deposition, however, quite a different reaction can occur – looks of initial amazement, followed by the inevitable face-off. "You can't do that." Can you?

What Does It Mean to Invoke "the Rule"

When someone invokes "the rule," he or she is seeking to implement the rule of sequestration – i.e., the rule requiring that certain witnesses remain outside of the presence of testifying witnesses.[1] The premise behind the rule is that it prevents witnesses from hearing the testimony of other witnesses so that each person's testimony is his or her own, and is not influenced or tainted because of another witness' testimony.[2] The rule may be invoked during trial, as well as during pretrial hearings at which witnesses are called to testify.[3]

Witnesses Who Are Not Subject to the Rule

Any discussion of the scope of the rule must begin with an analysis of those individuals who are not subject to the rule. According to the Florida Evidence Code,[4] there are four groups who may *not* be excluded from a trial or other proceeding. The first group includes a party who is a natural person.[5] Hence, in both civil and criminal matters, it is inappropriate to invoke the rule against a person who is a party to the lawsuit. The second group applies to civil actions, and concerns designated corporate representatives.[6] According to F.S. §90.616, a corporation or governmental body, which is a party, is treated the same as a natural person under the Florida Evidence Code.[7] Thus, just as a natural person who is a party may remain and hear testimony of other witnesses, so may a representative of a corporate party remain present during the testimony of another.

The third group is comprised of those individuals whose presence is shown to be essential to the offering party's cause.[8] This may include expert witnesses,[9] and, in criminal matters, law enforcement officers.[10] The final group, which pertains to criminal matters, includes victims of crimes, parents or guardians of minor child victims, a victim's next of kin and lawful representatives of a victim.[11] The trial judge has authority to exclude individuals within this last group if the court determines, upon motion, that their presence in the courtroom is prejudicial.[12]

Overview of the *Dardashti* and *Smith* Decisions

Two seminal cases discuss the subject of invoking the rule at deposition. In *Dardashti v. Singer*, 407 So. 2d 1098 (Fla. 4th DCA 1982), the plaintiff sued the defendant alleging breach of an oral contract.[13] In response to interrogatories, the plaintiff named as a witness his wife who was present during the alleged contractual negotiations and who would support the plaintiff's allegations.[14] The defendant sought to invoke the rule to sequester the wife from being present at the husband's deposition.[15] The trial court refused to sequester the wife from the deposition.[16] The Fourth District Court of Appeal reversed, holding that a party could invoke the rule at a deposition. It noted the nature of depositions – that is, that there is "little advance warning during a deposition of unexpected and oblique questions requiring instantaneous response[s]."[17] Moreover, the court reasoned that "[t]o permit [a person] to sit and absorb the answers of [another person] in a case such as [the one at hand] obviously facilitates the very 'coloring of a witness's testimony' frowned upon by [Florida's] Supreme Court in [*Spencer v. State*] . . .."[18] Hence, according to *Dardashti*, a party can invoke the rule during a deposition.

Some years after the *Dardashti* decision, the First District was called upon to address the rule in a deposition context. In *Smith v. Southern Baptist Hospital of Florida, Inc.*, 564 So. 2d 1115 (Fla. 1st DCA 1990), the First District did not follow the Fourth District rule. There, the plaintiff sued a physician and a hospital, as well as the hospital's Board of Regents, for negligence in failing to diagnose a circulation disorder, which ultimately resulted in a leg amputation.[19] The plaintiff

alleged that a resident who assisted the defendant-physician was negligent.[20] The resident, however, was not named as a defendant due to a statutory provision prohibiting officers and employees from being personally sued absent certain maliciousness or other bad faith.[21]

The plaintiff scheduled the defendant-physician for deposition during which plaintiff's counsel realized that the resident physician, a nonparty, was present.[22] Upon discovering who the resident physician was, plaintiff's counsel invoked the rule and asked that the resident physician leave the deposition room.[23] Defense counsel refused to exclude the resident physician.[24] The court denied the subsequent motion for protective order based upon the fact that the deposition had been in progress for some time prior to any sequestration being sought.[25]

The First District affirmed.[26] It stated that the "unwritten rule" – i.e., sequestration of witnesses – applied at trial and *not* during depositions.[27] The court reasoned that parties seeking to preclude persons from depositions needed to employ a motion for protective order by means of Rule 1.280(c).[28] Consequently, parties litigating in the First District could no longer invoke the rule during depositions, and instead, they needed to seek court intervention prior to the deposition.

In reaching its ruling, the First District analyzed the *Dardashti* decision, but was not persuaded to align itself with its sister court. The First District stated that: "In *Dardashti*, the [Fourth District] did not cite any case to support its conclusion that the unwritten rule of sequestration of witnesses at trial is applicable to deposition, and we have been unable to find any such case except *Dardashti*."[29] This led the First District to look to federal law for guidance. Specifically, the court looked to Federal Rule of Evidence 615 (the federal sequestration rule), as well as federal decisions interpreting Rule 615.[30]

The First District observed that federal courts applied Rule 615 to hearings and trials – *not* to depositions.[31] Federal courts instead required that parties implement Federal Rule of Civil Procedure 26(c) (i.e., motions for protective order) to exclude witnesses from depositions.[32] This was instrumental to the First District's *Smith* decision since Federal Rule 26(c) is virtually identical to Florida's Rule of Civil Procedure 1.280(c).[33] The court found the federal framework to be persuasive and chose to adopt the same logic for Florida.

Determining the Intent of F.S. §90.616

With the *Smith* holding, it became obvious that there was a split between the Florida District Courts of Appeal as to whether a party could or could not invoke the rule during depositions. The Fourth District in *Dardashti* ruled affirmatively that parties could use the informal sequestration practice, while the more recent *Smith* decision held that parties could not invoke the rule in a deposition. In 1990, the Florida Legislature added another component to this conundrum when it enacted F.S. §90.616.[34] The section states as follows: "At the request of a party the court shall order, or upon its own motion the court may order, witnesses excluded from a *proceeding* so that they cannot hear the testimony of other witnesses except as provided in subsection (2)."[35]

Ambiguity remains as to whether F.S. §90.616 was enacted to address the rule in the deposition context. In fact, Florida's Legislature has actually created further confusion for practitioners trying to navigate the already obscure discovery waters. The dilemma comes from the term "proceeding" as it is used in the Evidence Code.[36] Section 90.616 lacks a definition to clarify whether a "proceeding" includes a deposition. What is more, there is no apparent case law interpreting the term. Black's Law Dictionary defines the term "proceeding" as: "[t]he business conducted by a court or other official body; a hearing."[37] This suggests at least that a "proceeding" is restricted to hearings and other court-conducted matters.

Section 90.616's legislative history does provide some guidance as to what Florida's Legislature intended when it enacted the statute. It notes that out of the 31 states to enact a code of evidence, Florida was the only state without a provision governing the exclusion of witnesses.[38] With that said, the historical notes provide little direction beyond reciting this rather obvious motive. The best that one can glean from the historical notes is that the Legislature *may* have intended for the statute to apply to depositions insomuch as *Dardashti* is specifically referenced: "Consistent with the language in a case decided by the Florida Supreme Court [*citing to Spencer v.* State] and the language in a recent District Court of Appeal opinion [*citing to Dardashti*], the bill provides that exclusion of witnesses is a matter of right on demand of a party."[39] There is no reference to the First District's *Smith* decision in the legislative note.

Albeit inconclusive, the legislative history appears to favor and support the *Dardashti* view that the rule may be invoked at a deposition. There is another aspect of the mystery, however, which casts doubt as to this conclusion. The uncertainty comes when one looks to other Florida statutes to determine how Florida's Legislature has defined and applied the term "proceeding" in the context of other Florida laws. There is at least one Florida statute to look to for assistance in defining the term "proceeding." Section 90.801 (hearsay definitions and exceptions) uses the term "proceeding" in conjunction with the terms "trial," "hearing" and "deposition."[40] It provides:

> A statement is not hearsay if the declarant testifies at the trial or hearing and is subject to cross-examination

> concerning the statement and the statement is . . . [i] nconsistent with the declarant's testimony and was given under oath subject to the penalty of perjury at a *trial, hearing,* or *other proceeding* or in a *deposition*. . . .[41]

The fact that this statute, also in the Evidence Code, mentions a "trial, hearing, or *other* proceeding" suggests that a "proceeding" is analogous to a trial or a hearing.[42] However, a deposition is treated distinctly from trials, hearings, and other proceedings. The word "deposition" is placed at the end of the sentence and is independently identified after the term "proceeding." This provides evidence that on at least one occasion Florida's Legislature has declined to employ the word "deposition" interchangeably with the term "proceeding."[43] This interpretation of "proceeding" falls in line with Black's Law Dictionary insomuch as Black's equates a proceeding to a court-conducted matter.

To summarize, legislative history indicates that F.S. §90.616 was enacted, in part, to provide parties with the right to invoke the rule during depositions. If this is the state of affairs, then the term "proceeding" would include a deposition. Another Florida statute, also in the Evidence Code, however, conspicuously distinguishes depositions from proceedings.

Influence of the Federal Rules on F.S. §90.616

Federal law can be persuasive when tackling and resolving the motives behind Florida law. Unfortunately, under the scenario at hand, the federal influence has failed to provide a bright-line rule. One Florida court has followed the federal groundwork (i.e., the First District), while another court has not (i.e., the Fourth District). As indicated above, the First District relied upon federal law for guidance in reaching its *Smith* decision. Federal courts refuse to allow parties to use the federal evidence rule (Rule 615) as a means to invoke the rule during a deposition and instead require that a protective order be sought pursuant to Rule 26(c).[44]

The Fourth District's *Dardashti* ruling, on the other hand, did not follow the federal pattern. The Fourth District recognized Rule 615, but only to make mention of its surprise that Florida had not previously codified the rule as the federal system had done.[45] The court did not cite to federal case law discussing the rule or otherwise engage in any analysis to reconcile the fact that federal courts utilized Rule 26(c) (i.e., motions for protective orders), and not Rule 615, when dealing with the rule during depositions.[46] Instead, the Fourth District cited to Rule 615 for the general idea that parties could invoke the rule to exclude witnesses at trial. The court then bridged the gap between trials and depositions by explaining that the motivation for invoking the rule was similar in both circumstances.

Section 90.616's history indicates that the Florida Legislature was seeking to follow suit with the federal government, as well as the other code states, by enacting an evidence code concerning "the rule." Nonetheless, the Legislature apparently accepted the *Dardashti* viewpoint. Such a decision deviates from the federal framework insomuch as a *Dardashti*-backed §90.616 would mean that parties could invoke "the rule" during a deposition. Again, parties in federal lawsuits cannot employ Rule 615 as a measure to preclude a witness from a deposition. Instead, parties in federal litigation must move for a protective order via Rule 26(c).

Practical Considerations

So where do practitioners go from here? First and foremost, it would be prudent for a well-prepared litigator to construct a general deposition folder comprised of the *Smith* and the *Dardashti* decisions, as well as §90.616 (including the legislative history - ch. 174, 1990 Laws of Fla.). From there, the process can be described as nothing short of a truncated game of chess. While each litigator will obviously have his or her own unique approach to handling the rule at depositions, there are a few simple considerations to ensure well-reasoned arguments for either side.

As discussed above, the First District ruled in *Smith* that the rule does not apply in depositions in that district. Therefore, it is imperative to have the *Smith* case in hand if in the First District and your opponent attempts to invoke the rule during a deposition. If opposing counsel presses the issue, it may be wise to point out the position set forth in *Smith*, which states that parties must anticipate the need to prevent witnesses from attending a deposition and seek a preemptive protective order.

Now, if you find yourself in a situation in the First District where you believe you need to invoke the rule, another approach is needed. Although the *Smith* case clearly holds that the rule does not apply unless a protective order has been obtained, the prepared attorney still may argue that F.S. §90.616 applies and trumps *Smith*. As discussed previously, the Florida Legislature apparently aligned itself with the Fourth District's *Dardashti* decision. As an additional tool, you may want to raise an amendment to Rule 1.310, which took effect in 2008 pertaining to minors.[47]

The reasoning set forth above will work for the most part in the Fourth District by reversing the logic. Because the Fourth District held in *Dardashti* that a party may invoke the rule during a deposition, there obviously is no need to seek a protective order prior to the deposition.[48] Hence, in a perfect world, a practitioner can simply invoke the rule, much the same

• *Invoking "the Rule"*

as at trial. Opposing counsel may try to argue that the *Smith* case is more on point. However, the proper response is that *Dardashti* controls in the district. A prudent practitioner seeking to invoke the rule would also have F.S. §90.616 in his or her back pocket as the backup to *Dardashti*. At this juncture, it would also be wise to have the legislative history in hand to counter opposing counsel's inevitable argument that depositions were neither explicitly mentioned nor intended to be included under F.S. §90.616.

What about depositions in the Second, Third or Fifth districts? The above arguments are equally effective when employed in a district other than the First or Fourth. The tools for making a case to support the rule, or alternatively to oppose the rule, are the same as above. The fundamental approach is simply to understand the case law, as well as the statute, to ensure that persuasive arguments can be made to support the chosen position.

Conclusion

Until the courts clarify the scope of the rule as it applies to depositions, the ambiguous and uncertain interplay between the *Dardashti* and *Smith* decisions, as well as F.S. §90.616, permit the creative attorney to argue that the rule should or should not apply given the exigencies of the case. The most direct approach to clarifying the issue would seem to be for the Florida Legislature to amend F.S. §90.616 to include a definition of "proceeding," which would in turn specifically include the term "deposition." Until that occurs, practitioners will be left with *Smith* versus *Dardashti*, with a taste of F.S. §90.616 on the side. These materials are tools in the Florida lawyer's toolbox that can be used to provide the best possible arguments for or against invoking the rule at depositions.

Bryan R. Rendzio, Esq., *Jacksonville, FL, has been recognized as a an expert in construction law by the Florida Bar and by Florida Super Lawyer Magazine as a Rising Star in Construction Law. As a shareholder of Tritt | Rendzio, Mr. Rendzio's experience is in litigating a variety of construction defect and construction lien matters for developers, contractors, subcontractors, manufacturers, suppliers and insurance companies and, for the past several years, condominium associations. He has sued on behalf of owners, developers, unit owners and condominium associations, and has defended developers, contractors, engineers and subcontractors in construction defect litigation involving, among other things, roof design, building envelope and water intrusion, construction issues, mechanical equipment design and construction, EIFS-related issues and overall design defects*

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Endnotes:

1 *See* FLA. STAT. §90.616 (2007); *see also* C. EHRHARDT, FLORIDA EVIDENCE §616.1 (2006 ed.)(Professor Ehrhardt states that "[i]n order to avoid a witness coloring his or her testimony by hearing the testimony of another, any party may invoke the rule of sequestration of witnesses after which the trial judge will ordinarily exclude all prospective witnesses from the courtroom") (internal citations omitted).

2 *See* C. EHRHARDT, FLORIDA EVIDENCE §616.1 (2006 ed.) (internal citations omitted).

3 *Id.*

4 *See* FLA. STAT. §90.101 (Chapter 90 of the Florida Statutes is referred to as the "Florida Evidence Code").

5 *See* FLA. STAT. §90.616(2)(a) (2007); *see also Ferrigno v. Yoder*, 495 So. 2d 886, 888 (Fla. 2d DCA 1986).

6 *See* FLA. STAT. §90.616(2)(b) (2007); *see also Goodman v. West Coast Brace & limb, Inc.*, 580 So. 2d 193 (Fla. 2d DCA 1991).

7 *See* C. EHRHARDT, FLORIDA EVIDENCE §616.1 (2006 ed.).

8 *See* FLA. STAT. §90.616(2)(c) (2007).

9 *See* C. EHRHARDT, FLORIDA EVIDENCE §616.1 (2006 ed.)

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• Invoking "the Rule"

(providing a useful example of a complex business fraud case wherein an C.P.A.-expert would be permitted to remain in the courtroom to advise counsel and to testify to an expert opinion; further noting that experts are less likely to be subject to exclusion than fact witnesses since experts testify as to opinions as opposed to factual matters).

10 *See* C. EHRHARDT, FLORIDA EVIDENCE §616.1 (2006 ed.) (internal citations omitted).

11 *See* FLA. STAT. § 90.616(2)(d) (2007).

12 *See* C. EHRHARDT, FLORIDA EVIDENCE § 616.1 (2006 ed.) (internal citations omitted).

13 *Dardashti v. Singer*, 407 So. 2d 1098 (Fla. 4th DCA 1982).

14 *Id.* at 1099-1100 (noting that the plaintiff named his wife as a witness "on no less than [14] occasions" in his interrogatory responses).

15 *Id.*

16 *Id.*

17 *Id.*

18 *Id., citing Spencer v. State*, 133 So. 2d 729 (Fla. 1961).

19 *Smith v. Southern Baptist Hosp. of Florida, Inc.,* 564 So. 2d 1115, 1116 (Fla. 1st DCA 1990);

20 *Id.*

21 *Id.*

22 *Id.*

23 *Id.*

24 *Id.*

25 *Id.*

26 *Id.*

27 *Id.* at 1117.

28 *Id.* at 1118; *citing* FLA. R. CIV. P. 1.280(c)(5)("Upon motion by a party or by person from whom discovery is sought, and for good cause shown, the court in which the action is pending may make any order to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense that justice requires, including . . . (5) that discovery be conducted with no one present except persons designated by the court").

29 *Id.*

30 *Id.*

31 *Id.*

32 *Id.*

33 *Id.*

34 *See* FLA. STAT. §90.616 (2007); *see also* Michael Flynn, *Invoking What Rule?*, 24 NOVA L. REV. 367 (1999)(discussing the circumstances surrounding the enactment of FLA. STAT. §90.616) (internal citations omitted).

35 FLA. STAT. §90.616(1) (2007).

36 *See* Michael Flynn, *Invoking What Rule?*, 24 NOVA L. REV. 367 (1999)(discussing use of the term "proceeding" in section 90.616) (internal citations omitted).

37 BLACK'S LAW DICTIONARY 1241 (8th ed. 2004).

38 *See* 1990 Fla. Laws ch. 174.

39 *Id.* (*Spencer v. State* is discussed *supra*).

40 *See* FLA. STAT. §90.801 (2007).

41 FLA. STAT. §90.801(2)(a) (2007).

42 *Id.*

43 *Id.*

44 *See, e.g., BCI Communication Sys., Inc. v. Bell Atlanticom Sys.,, Inc.,* 112 F.R.D. 154 (N.D. Ala. 1986); *see also Skidmore v. Northwest Eng'g Co.,* 90 F.R.D. 75 (S.D. Fla. 1981).

45 *See Dardashti v. Singer,* 407 So. 2d at 1100 (Fla. 4th DCA 1982).

46 *Id.*

47 FLA. R. CIV. P. 1.310 was amended, effective 2008, to include a section pertaining to the depositions of minors. FLA. R. CIV. P. 1.310(b)(8) states that

> "[a]ny minor subpoenaed for testimony shall have the right to be accompanied by a parent or guardian at all times during the taking of testimony notwithstanding the invocation of the rule of sequestration of section 90.616, Florida Statutes, except upon a showing that the presence of a parent or guardian is likely to have a material, negative impact on the credibility or accuracy of the minor's testimony, or that the interests of the parent or guardian are in actual or potential conflict with the interests of the minor." (Emphasis added). This inclusion provides evidence of the Florida Supreme Court's position that the rule may pertain to depositions. Regardless of which position you are arguing on the subject, it would be prudent to disclose the existence of FLA. R. CIV. P. 1.310(b)(8) to the Court to ensure full disclosure to the Court and opposing parties.

48 The author to this article has encountered numerous comments from practitioners as to whether counsel may simply state that he or she is invoking the rule during a deposition in an effort to sequester witnesses. There are two lines of thought on this matter. One side argues that even if the rule applies to depositions, counsel does not have the authority to invoke the rule during a deposition, and instead of seeking a protective order must still obtain a preemptive ruling from the Judge authorizing the sequestration (i.e., a ruling from the Judge which does not require the heightened burden imposed by FLA. R. CIV. P. 1.280(c)(5)). The other line of thought is that counsel has the right and authority to state to the parties during a deposition that he or she is invoking the rule after which the person who is the subject of sequestration must leave the deposition room. This nuance is not addressed in this article, however, the author has seen the latter scenario occur during depositions on various occasions (i.e.,

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Process, How Much is "Do"?

By David B. Langham, Deputy Chief Judge of compensation Claims, Office of the Judges of Compensation Claims

Due process is a concept dear to the American adjudicatory process, with deep roots in the U.S. Constitution. It is a concept that most lawyers spend significant time studying in law school, and then tend to take for granted as they evolve into the practice of law. The process for Florida workers' compensation motion practice affords everyone sufficient due process, essentially notice and an opportunity to be heard. Unfortunately, after those opportunities have been afforded to the parties, one of them periodically asserts in retrospect (motion to vacate or for rehearing) that they have been denied due process. Coincidentally, it is usually the non-prevailing party that makes this assertion. Counsel should focus on assuring their client's due process before a ruling, and doing so simply requires understanding and following Rule 60Q6.115. The following are some basic reminders of "dos" and "don'ts" of workers' compensation motion practice with the goal of helping the practitioner navigate the perils of workers' compensation with greater ease and less frustration.

Do make every effort to resolve conflicts between counsel and/or parties without the expense and effort of a motion. Too many times, the motion is the first communication. It is drafted in frustration, desperation, or even anger and transmitted to opposing counsel with a terse "take or leave it" cover letter: "if you do not respond immediately, I am filing the enclosed." This is not appropriate. With very few exceptions (motions to dismiss for lack of prosecution) the moving party is required to "*personally confer* with the opposing party or parties or, if represented, their attorneys of record to attempt to amicably resolve the subject matter of the motion." Rule 60Q6.115(2)(emphasis added). The Guidelines of Professional Conduct adopted by the Section and the judges (hereafter "the Guidelines") adopt and endorse the communication requirement.

Webster's defines "personally" as "in *person***:** as a person**:** for oneself: in a personal manner." Webster's defines "confer" as "to compare views or take counsel." Taking these simple words to heart, the rule requires that before a motion is filed there is communication between the principals that involves comparing views; a "conversation," which includes give and take. Don't have your paralegal call their attorney or paralegal. Don't send a terse "take it or leave it" cover letter and draft motion. Don't presume or assume that you have a dispute. Do pick up the telephone and discuss your issue with the opposing party or attorney. Communication in the modern world is deeply technological. Email, facsimiles and texts are quick, efficient, and make great tools for the right task. This is not one of them. Conflict is resolved through conversation and sharing of views about the perceived conflict.

Do draft a specific motion if a motion is indeed necessary. Motion drafting is not a job for most paralegals or support staff. It is not a task for rote forms and boiler-plate language. It is a task for attorneys. More specifically, it is a task for the attorney responsible for this case. Certainly, associates, paralegals and staff may have valid roles in this process within your office. However, the responsible attorney should draft the motion. In a multitude of motion hearings, judges find that the actual dispute between the parties is not the dispute expressed in the motion. Often this results from a paralegal or associate preparing what they think the responsible attorney seeks. I recognize that time is precious and attorneys must be efficient and may not have hours to devote to a motion. However, an attorney can prepare a good motion, or at least read and review one prepared by others when necessary, in a reasonably short time. As an illustration of the perils of forms, there are still motions filed citing the Supreme Court rules of Workers' Compensation Procedure (which were superseded in 2003).

Counsel should focus on assuring their client's due process before a ruling, and doing so simply requires understanding and following Rule 60Q6.115.

Do express accurately the position of the opposing party in the motion. This expression is required by Rule 60Q6.115(2)("All motions shall include a statement that the movant has personally conferred or has used good-faith efforts to confer with all other parties or, if represented, their attorneys of record and shall state whether any party has an objection to the motion"). The rule requires that "any motion filed without this certification ***shall*** be summarily denied." (Emphasis added). Attorneys do forget this representation, and motions are denied as a result. Time is wasted. It becomes increasingly self-evident that time is money. Efficient attorneys will assure that this clause is present, so that *this* motion is decided on the merits, rather than *the next* motion, after investment of more time for repetitive filing. Professional attorneys will assure that their personal conferring results in this clause being accurate. If you can't reach the opposing attorney or party, simply describe your unsuccessful efforts (i.e. "counsel called and left three messages before filing this

motion and must presume the opposing party objects to this motion").

Do understand that people make agreements. We appropriately expect that people will be honorable in the vast majority of their dealings with others. It would inspire incredulity if anyone proposed that every contract executed in our society should be blessed by some adjudicatory authority. When you sign a vehicle contract, do you send it to the circuit court for approval? If you do not, will you still make the car payments or claim you need not because it was not "blessed" with a court order? When you lease a copier for your office, is that lease agreement "blessed" with a court order? Is your malpractice insurance contract invalid if it is not "blessed" with a court order?

Do understand that orders are not ordinarily necessary for parties to enter an agreement. Rule 60Q6.115(3) addresses this, and requires that a "motion which is unopposed shall state why an order is necessary to execute the parties' agreement." This requires more than recitation of boiler-plate language: "an order is necessary to effectuate this." This motion rule is a parallel to 60Q6.116(5):

> "Except as authorized by statute, the judge may enter an order reflecting the terms of any written stipulation or agreement between the parties only where one of the parties to the stipulation or agreement alleges that another party has failed or refused to comply with the stipulation or agreement and an order is necessary for immediate enforcement."

The resources of the adjudication system are for the resolution of disputes. Certainly, if an order is required, then a motion, joint or otherwise, is the appropriate vehicle. 60Q6.115(1)("Any request for an order or for other relief shall be by motion"). However, if there is no dispute, answer the question first, why must this agreement/contract be "blessed." Ask yourself whether the chance or potential that one side might not do that to which they have agreed is sufficient to justify the time involved in obtaining an order; your time and judicial time. Can you picture a car dealer with a straight face asking a Circuit Judge to approve an auto sale agreement, saying "Judge if you do not approve the contract, we are afraid the buyer won't make a payment at the end of the month?"

We hear that the "other" party will not follow through without an order. If no judges entered orders on undisputed stipulations, and the parties therefore no longer felt any entitlement to such an order, that paradigm would change. Parties that agreed to pay something or send something would perhaps do so without an order, just as you send your car payment each month, despite the contract having no judicial blessing.

Do understand that if your motion says that the opposing party(ies) agree, that will likely be relied upon. Judges have every right to believe attorneys are telling the truth. The Rules of Professional Conduct say attorneys will tell the truth. Rule 4-3.3 ("A lawyer shall not knowingly: make a false statement of fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to the tribunal by the lawyer"). When your motion says that the opposing party does not disagree, this statement will be taken as the truth. It is very disturbing for a judge when she/he finds from a motion for rehearing that such a statement was allegedly not true.

Do communicate when disagreements resolve. An American proverb says "time heals all wounds." It is possible that time itself will resolve your conflict. If a motion has been filed, and the dispute resolves upon further reflection or consultation, notify the judge. Filing a simple "withdrawal of motion to __________" will alert the judge that this motion no longer requires her/his time. Filing this notice puts the fact that adjudication is not required in the same place (the docket) as the motion. This documents and organizes. A phone call to the judge's office may seem simpler, but this simply shifts the burden to judicial staff to document the case to reflect that oral representation (they would likely put a note in the management program's "case comments," which will not be as obvious as your notice in the docket). The simple courtesy of a one page "notice of withdrawal" will prevent time wasted and facilitates the judge's and judicial staff's focus upon the motions that do require attention.

Do expect that your motion will result in an order. In the vast majority of situations, this is a reasonable expectation. The process is, and frankly should be, simple. At the risk of repeating what should be clear from the foregoing: motions should not be filed until the parties know there is a dispute (after a conversation); motions should accurately represent that the opposing party(ies) agree or disagree with the motion; when the time comes for entry of an order, the docket should reflect if the motion is withdrawn.

With this foundation, litigants should be able to expect the adjudicatory process to likewise demonstrate a respect for and compliance with the rules. Judges must appreciate that the Motion is a representation that there is a genuine dispute among these parties, and an order resolving that dispute will facilitate the progress of this case toward overall resolution or adjudication. As a side note, attorneys that draft succinct motions, confer in person, represent opposition accurately, and withdraw later-resolved motions, encourage prompt judicial attention to motions.

The process should be simple. Rule 60Q6.115(4) provides the outline. If the dispute is not resolved through the consultation (i.e. when they "confer"), then the motion is filed. The motion should accurately represent that there is or is not opposition. If the motion represents that there is not opposition, an order may be entered immediately. If there is opposition, the judge will usually ("when time allows," 6.115(4)), afford a window of opportunity for the opposing side to file

• *How Much Is "Do"?*

a written response. There is no requirement that the opposing party file a response; there is no requirement that the judge wait indefinitely for one to be filed. However, if a party does not want the motion granted, it is incumbent upon them to tell the judge why. If a party chooses not to file a response telling the judge why, they should not be surprised if the judge grants the motion in light of their silence. By the same token, JCCs should be cognizant to not enter orders on motions where the party opposing the motion (or at least intending to do so) has not been given the full 15 days to respond under Rule 60Q6.115(4). If time constraints are too much (you find yourself in a week-long jury trial and under all the constraints that entails), consider filing a single line "motion to extend time," i.e. "the undersigned is engaged in a week-long jury trial and cannot adequately respond to the motion for ________ until ________, xx, 2012. The undersigned therefore requests extension of the time for response until ________, xx, 2012.

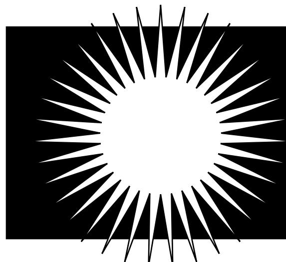
Motion hearings are available for argument of motions. Lawyers periodically complain that "there are no motion hearings." Motion hearings are available in "exceptional circumstances and for good cause shown in the motion or response." Rule 60Q6.115(4). Judges differ in their interpretation of this rule. Some conclude that if a dispute exists between two attorneys, then this is an "exceptional circumstance." Other judges find attorney disagreements unexceptional generally. Attorneys rarely employ this Rule effectively, and often complain about the result. If a motion hearing is required, say so! If you are responding to a motion and feel a hearing is necessary, say so! Not in the motion for rehearing or to vacate, but rather "in the motion or response." Rule 60Q6.115(4).

Mahatma Ghandi said "if you don't ask, you don't get." Time and again attorneys file motions for rehearing or motions to vacate. In them, they provide extensive detail about extraordinary and difficult circumstances, failures in their opponent's factual recitations, and misconceptions or conclusions by the judge. Some of those attorneys complain to me that the judge should not have granted or denied the particular motion, or that the judge should have held a hearing. Reviewing the pleadings, I often find that although the attorney now proclaims a hearing was critical, neither the motion nor the response (if one was even filed) expresses any exceptional circumstance. In the vast majority of those situations, there is no request for a hearing in either the motion or the response. It is disingenuous, at best, to complain about the process (entry of an order without a hearing), when you have failed to engage the process (ask for a hearing and explain the exceptional circumstances that require a hearing). That is not to say that the judge must agree with you and hold a hearing. However, if you don't ask, you will never know what the answer was.

Similarly, several attorneys have asked recently why a judge would decline to grant their motion for a "stay." The Court has held that the "authority to grant a stay has not been specifically delegated to the Judges of Compensation Claims by the legislature." *See, Alachua County Detention Center v. Alford*, 727 So.2d 388, 389 (Fla. 1st DCA 1999). The court also noted "The E/C cited no such authority in their motion seeking the stay." The "do" here is clear. Ask for the relief you seek, and it never hurts to provide the judge with authority that supports that the relief sought is within their power. As an aside, since a "stay" is not, ask for something that is within the judge's power, such as a continuance or a request for extension of time under Rule 60Q6.115(5).

Due process is due. Parties should be able to present their disputes to the judge. Most will be capable of being handled by written motion and written response. Hearings will be held in "exceptional circumstances." Judges will rely upon the parties ("in the motion or response") to tell them when those circumstances exist. Judges should review motions when they are filed and expeditiously enter orders on those that are both required and unopposed. Judges should review all other motions fifteen days (Rule 60Q6.115(4)) later and consider them in light of any response filed, or in light of the absence of any response. Judges should then enter an order on those motions within a reasonable time or schedule an expeditious hearing, evidentiary or otherwise. In no circumstances should a procedural motion linger on a judge's docket for an extended period without entry of some order, if it only clarifies questions or sets a hearing or requires submission of more information. The rights of the parties are not protected if a motion is ignored. When the JCC fails to provide a timely ruling, the necessity of a ruling should politely be brought to their attention, or to mine.

All attorneys are cognizant of Due Process. To assure that their client receives Due Process, attorneys must focus on how they "do process" their motions and responses. If attorneys "do (the) process" appropriately, they should expect that judges likewise "do process" their motions within the parameters of the 60Q rules. In the end, all this "do process" will assure Due Process, and an efficient and effective adjudication system for workers' compensation disputes.



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Legislative Update

By Fausto Gomez, Esq., Section Lobbyist, Miami, FL

Dear Friends:

The legislative session concluded at midnight on Friday, March 9th, with only minor adjustments to the practice of workers' compensation. Facing a year in which over a dozen significant changes to workers' compensation were proposed, with legislation filed in the Senate and House as well as a Budget Conforming Bill, the bills that passed were the repeal of the Workers' Compensation Reporting Requirements (SB140), legislation seeking to eliminate fraud in workers' compensation as allegedly facilitated by check cashers (CS/HB1277), and a repeal of the 32-year old law that requires workers' compensation insurers to return premiums to policyholders if they are in excess of 5 percent of their anticipated underwriting profits (HB941). CS/HB1277 was a priority of Chief Financial Officer Jeff Atwater and statutorily establishes the recommendations of the "Money Service Business Facilitated – Workers' Compensation Work Group" he formed late last year. HB941 was amended on the last day of session to include the excess profit provision and passed that same day as part of a larger strike-all amendment. It was never heard in any committee of the Senate.

Not passing were the elimination of the statewide Workers' Compensation Judicial Nominating Commission, the elimination of 440.491, F.S. (dealing with the rehabilitation of injured workers), modifications to the Certificate of Exemption process, legislation reducing the look-back period for calculating penalties for failure to comply with workers' compensation coverage requirements from three years to one year, the requirement that health care providers in the workers' compensation system be certified by the Department of Financial Services in order to be eligible for reimbursements for services rendered, and the bills revising the amount of reimbursement for prescription medications of workers' compensation claimants by providing that the reimbursement amount is the same for repackaged or relabeled drugs as for non-repackaged drugs. As you may recall, both National Council on Compensation Insurance (NCCI) and the Office of Insurance Regulation (OIR) argued that if the bill passed, a reduction in workers' compensation premiums would be in order.

The following is an outline of the two bills that were approved. But more important were the negative changes, listed above, that your lobby team was able to avert. Jeff Jacobs, Richard Chait, Paul Anderson, and Rick Morales deserve special thanks for their involvement and guidance during the course of the legislative session. Many of these were hard fought items and they joined me as articulate advocates for the positions adopted by the Section. And, as always, let me conclude by saying that I am honored to represent you, and I trust you will not hesitate to contact me if you have any questions or desire additional information.

Repeal of Workers' Compensation Reporting Requirements (SB140)

Touted as a cost-savings measure, SB140 and its companion measure, HB4019, were approved unanimously in their respective chambers. The bill repeals s.440.59, F.S., which required the Department of Financial Services (DFS) to prepare an annual report on the administration of the Workers' Compensation Law for the preceding calendar year. The report included a detailed statement of the receipts of and expenditures from the Workers' Compensation Administration Trust Fund and a statement of the causes of the accidents leading to the injuries for which the awards were made. On or before September 15th of each year, DFS was required to submit a copy of the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Democratic and Republican Leaders of the Senate and the House of Representatives, and the chairs of the legislative committees having jurisdiction over workers' compensation.

The 2011 Annual Report of the Florida Division of Workers' Compensation contains narrative, as well as charts and graphs depicting the activities of the division. In addition, the report includes information regarding claims, such as the nature of the injury, cause of the injury, body location of workplace injuries, and medical data. The Division of Workers' Compensation stipulated that the report was not necessary since it maintains a website that provides data, forms, publications, and other information to assist injured workers, employers, insurance carriers, health care providers, and other interested parties. Information concerning the division's program area and claims data is also available at the website.

Money Services Business (HB1279)

In 2008, the Attorney General impaneled the Eighteenth Statewide Grand Jury to look into the issue of fraudulent insurance and other organized criminal

continued, next page

• *Legislative Update*

enterprises. As a result, Ch. 560, F.S., Money Services Business, underwent a major re-write to address concerns with fraudulent insurance and money laundering activities. However, what the prior legislation did not cure was the problem of facilitators creating shell companies for the purpose of purchasing workers compensation insurance policies and then, for a fee, allowing uninsured contractors to use those certificates of insurance.

The scheme involves facilitators, contractors, and money services businesses. Facilitators create fake shell companies, typically incorporated online through the Department of State. The shell companies then purchase a minimal workers' compensation insurance policy. The facilitator may then approach an uninsured subcontractor who lacks the valid workers' compensation policy necessary to obtain contracts from a general contractor. The facilitator makes the shell company's name and workers' compensation policy available for use by the uninsured subcontractor, for a fee. Subsequently, a general contractor, knowingly or unknowingly, uses the uninsured subcontractor to perform work.

Once the uninsured subcontractor completes work under the guise of the shell company, payment will be made to him/her from the general contractor via company check made payable to the shell company. Typically, the check cannot be cashed at a bank because most banks will not cash a check made payable to a business or third party. However, money service businesses will allow the cashing of the third-party business-to-business checks by certain "authorized" persons related to the payee. These "authorized" persons are the facilitator and others designated by the facilitator.

HB1279 seeks to thwart this practice by eliminating the requirement that the Office of Financial Regulations (OFR) provide a 15-day advance notice to money services business licensees prior to conducting an examination or investigation. This change reduces the opportunity for hiding, destroying, or otherwise tampering with records and materials which may be pertinent to an examination or investigation. The bill further requires that a check cashing business deposit payment instruments into its own commercial account at a federally insured financial institution and deletes the authorization to sell payment instruments within 5 business days after acceptance. And finally, the bill stipulates that a check casher may only accept or cash a payment instrument from a person who is the original payee or who is an authorized officer of the corporate payee named on the instrument's face. Acceptance and cashing of third-party checks is no longer authorized.

Excess Profits (HB941)

Legislation to eliminate the excess profit limitation for workers' compensation insurance carriers was filed in the House of Representatives by Rep. Don Davis. While it passed the House there was no Senate companion and was never heard in any committee in that Chamber. It passed the Senate as part of large "strike-all amendment" sponsored by Senator Chris Smith to HB941 on the last day of the legislative session.

The Office of Insurance Regulation reported that it collected nearly $16.7 million in excess profits from insurers in 2010 and 2011 and since 2003 OIR has collected $200 million. But Associated Industries of Florida General Counsel Tami Perdue told lawmakers the excess profit law is antiquated and no longer necessary. "This is in line with what we have done over the past years," she said. "Find areas where there are laws that are over-burdensome, regardless of what their industry is, and eliminate them."

Since 2003, workers' compensation rates have dropped by 58 percent, although they have risen the past two years. Those rate cuts have been in addition to the downturn in the economy that has cut the state's private carrier premium base from $1.5 billion in 2007 to a projected $1 billion in 2010.

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Medicare Set Asides – How Are They Administered?

By Jason D. Lazarus, J.D., LL.M., MSCC, Orlando, FL

When a case is settled for a Medicare beneficiary, be it workers' compensation or liability, a Medicare Set Aside ("MSA") may be implemented. Once the decision is made to utilize an MSA, the question becomes how will it be administered? The criteria for MSA administration is that the funds may only be used to pay for future medical expenses of the type normally covered by Medicare for treatment of the injury victim's injury related medical conditions. CMS's guidelines (for workers' compensation cases) indicate that set aside funds should be placed in an interest bearing account and may be either professionally administered or self administered. If the injury victim self administers the set aside, the claimant is supposed to submit an annual self attestation form when the monies in the set aside have been exhausted. If the set aside is professionally administered, the MSA administrator must prepare an annual accounting summary concerning the expenditures from the set aside and send it to the CMS Medicare contractor responsible for monitoring the individual's case.

The MSA administrator, whether it is the injury victim or a professional administrator, must make sure that the set aside pays at the proper rate; that funds are spent only on Medicare covered expenses and that Medicare does not pay for injury related care until the set aside funds are exhausted. As for the first responsibility, the set aside is supposed to pay based upon how the set aside was calculated. For example, in workers' compensation cases the set aside is usually calculated based upon the state workers' compensation fee schedule. For liability settlements, it is generally usual and customary rates. So the set aside administrator should pay at the appropriate rate as determined by the calculation of the set aside allocation. If the provider does not agree to accept payment at the appropriate rate, the balance of the cost must be paid with funds outside of the MSA. The MSA administrator isn't required to determine what would be the Medicare approved charges and there isn't a need to consider Medicare deductibles or co-payment amounts. This may seem a bit foreign, but it is the proper way to make payments out of the set aside.

As for the second responsibility, the set aside can only be used for Medicare covered expenses related to the injuries. The set aside monies must be spent appropriately and this must be documented or Medicare could reject future care until the set aside is properly replenished with funds. Lastly, the set aside funds must be properly exhausted before Medicare is billed by providers. There are two type of exhaustion, temporary or total. The type of exhaustion depends on how the set aside has been funded. If the set aside is funded with an annuity then each year there is a potential for temporary exhaustion. The way this works is that at inception the set aside is funded with a "seed" amount (lump sum) and then annual annuity payments. If in any one year the set aside is exhausted, then Medicare picks up for the remainder of the year. When the next annuity payment comes in then that must be exhausted before Medicare will pay. It works like an annual deductible. If the set aside is funded with a lump sum then all of the funds must be exhausted before Medicare pays for injury related care.

As you can see this can be quite a complex undertaking for the average injury victim. Proper self administration of a set aside is difficult for the average injury victim. There are companies that provide self administration support services that can assist injury victims in managing their set aside accounts. However, the degree to which these are effective is dependent on how compliant the injury victim is in following through with the services. For many larger cases, professional administration is a much better option even though it is more expensive. The set aside monies can only be used for Medicare covered medical services. If a professional administrator is used, it has to be paid from the non-Medicare Set Aside settlement proceeds. Typically, the set aside administrator is paid by an annual annuity that is set up just to pay for the services. The set aside administrator can also be paid by a lump sum, but again it has to come from monies outside of the amount allocated to the Medicare Set Aside. Attorney fees related to the set aside administration or legal issues that may arise in administering the set aside similarly can't come from the monies in the set aside.

Most professional administrators of set asides provide the service through a custodial arrangement. These custodial arrangements are contractual agreements and don't create the same level of fiduciary obligation on the part of the administrator as is possible with a trust. One problem with a custodial set up is the protection afforded to the monies in the event of a bankruptcy of the set aside custodian. Would the funds be lost? Would the funds be exposed to bankruptcy creditor claims? Before entering into a custodial arrangement, you as counsel for the injury victim, should investigate the financial security of the custodian; status of bond or insurance on

• *Medicare Set Asides*

performance as custodian; whether the injury victim's MSA funds will be fully insured; past performance of investments and whether there is any history of legal or financial problems related to set aside administration.

A better alternative, in my opinion, is the creation of a Medicare Set Aside trust ("MSAT") agreement. An MSAT is a formal trust agreement administered by a corporate trustee typically paired with a professional Medicare Set Aside administrator. With an MSAT, you get a trustee that has a fiduciary duty paired with a set aside administrator who can handle the intricacies of managing set aside funds and reporting to CMS. If the trustee or administrator can no longer perform their duties, a new trustee or administrator may be appointed but the fidicuciary obligations and creditor protections of the trust remain. Trusts are covered by state trust and fiduciary laws. Typically custodians don't need any type of licensure whereas trust companies or banks do, which is another layer of protection for the injury victim's funds.

There are some things that are important to recognize about set asides in general. First, the monies belong to the injury victim not Medicare. This means at death the unused funds go to the injury victim's beneficiaries (assuming the custodial agreement or trust provide for this). When the injury victim dies, the set aside should be left "open" for 15-27 months since Medicare providers have a long period to bill for services rendered and there may be bills the set aside must pay. Second, the interest earned on the monies in the set aside are taxable but the set aside funds can be used to pay taxes. The interest is retained in the set aside and can't be withdrawn. Third, if a settlement involves someone incompetent to handle their own affairs then obviously a professional administrator must be used. Fourth, if an injury victim is eligible for both Medicaid and Medicare then the set aside should be inside of a special needs trust to preserve all available benefits and professional administrator is necessary. Lastly, to date there are no "Medicare Set Aside police" monitoring set asides but if it is improperly administered then that can lead to a loss of coverage for injury related Medicare covered services. In the event of improper expenditures, the injury victim would have to replenish the set aside and exhaust those funds properly before getting Medicare coverage again for injury related care. Accordingly, it is vitally important to make sure the set aside is properly administered. Given the government's increased efforts to enforce the Medicare Secondary Payer Act a la mandatory insurer reporting, CMS has more information than ever to make sure of proper enforcement.

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Medicare's New Reporting Law & the Workers' Compensation Lawyer
How Do I Fit (and Not Fit) Into this Process?

By Mark Popolizio, Esq., Miami, FL

Over the past several years, the Centers for Medicare and Medicaid Services (CMS) have intensified its efforts to enforce Medicare's rights under the Medicare Secondary Payer Statute (MSP).[1] Recent implementation of Medicare's new reporting law, Section 111 of the Medicare, Medicaid and SCHIP Extension Act (Section 111),[2] has armed CMS with an important and potent tool to identify cases involving Medicare beneficiaries.

Section 111 reporting is now entering its second year for workers' compensation claims. During this time, awareness and knowledge of this new law has certainly increased. However, many practitioners still have questions regarding important aspects of Section 111 such as: *What obligations do I have under Section 111? What role do I play in this process? How does Section 111 affect my client? When is reporting required? How does Section 111 relate to other MSP compliance obligations?*

Through this article, the author breaks down and pieces together Medicare's new reporting law with the aim of assisting those practitioners who may have remaining questions regarding Section 111's requirements and where they fall within the larger Section 111 reporting process.

How is CMS Implementing Section 111?

CMS is implementing its Section 111 requirements for non-group health (NGHP) claims through its "Mandatory Insurer Reporting (MIR)" directives. Information regarding the MIR may be obtained at www.section111.cms.hhs.gov and www.cms.gov/MandatoryInsRep.

The main MIR compliance document is the **NGHP User Guide**. To date, CMS has released six editions of the NGHP User Guide. At the time this article was drafted, the operative User Guide is Version 3.3, dated December 16, 2011. CMS periodically updates the User Guide via Section 111 "Alerts." Since 2008, CMS has been holding regular Section 111 "Town Hall" teleconferences to discuss its MIR directives and address questions from the public. As the MIR remains a "work in progress," CMS' Section 111 websites should be routinely checked to stay abreast of all updates and pertinent developments.

Who Reports Under Section 111?

The party obligated to report under Section 111 is called the "Responsible Reporting Entity (RRE)."

RREs are required to (i) determine a claimant's Medicare status and (ii) report claims involving Medicare beneficiaries to CMS if the claim meets a Section 111 "reporting trigger." The penalty for non-compliance is steep: $1,000 per day, per claim.

A complete examination of CMS' RRE directives is outside the scope this article.[3] In general, RRE determination is fact and situational specific in accordance with CMS' specific criteria. While a number of different parties could potentially be RREs, in many instances RREs will typically be carriers and self-insureds. In rare situations, a third party administrator (TPA) may be a RRE. It is important to note that claimants are ***not*** RREs. Likewise, lawyers in their respective representative capacities are ***not*** RREs.[4]

A RRE may use a Section 111 "reporting agent" to process its required Section 111 reports. However, the RRE remains ultimately liable for Section 111 compliance.[5] Furthermore, the agent must be properly registered by the RRE through the Section 111 registration process.[6]

Common entities currently serving as Section 111 agents include, TPAs, Medicare/MSA services vendors and companies specializing in data collection and transmission. Conceivably, a law firm (e.g. a defense firm) could be a Section 111 agent assuming it has built the proper electronic reporting system and has the technical knowledge required under Section 111. Furthermore, the firm would need to be properly registered as an agent by the RRE. To the author's knowledge, very few law firms are serving as Section 111 reporting agents.

On a practical level, knowing the RRE/Agent dynamic will generally be immaterial to the claimant lawyer. For the defense lawyer, knowing the RRE/Agent arrange-

ment is important in terms of general client knowledge and determining what counsel's expected role may be in the Section 111 process. In certain situations, defense counsel could play an important part in educating the client regarding Section 111 where the client has not erected reporting protocols or is otherwise unfamiliar with the reporting mandates.

Determining Medicare Status

RREs are required to determine a claimant's Medicare status. Here is where Section 111 will likely have particular trench level impact for workers' compensation lawyers (as well as their counsel brethren handling non-workers' compensation injury claims). Let's examine why and how.

CMS' Query Process System

While RREs are statutorily required to determine a claimant's Medicare status, the Section 111 statute does *not* provide a specific process for the RRE to utilize to make this determination. To assist RREs, CMS developed a "Query Process" system whereby RREs may submit electronic query requests once a month to determine an individual's Medicare status. Only RREs or their registered Section 111 reporting agents may utilize this system.

In order to use Query Process, the claimant's social security number (SSN) or health identification number (HICN) is a *required* data element. In addition, the RRE must submit the following information: first initial of the claimant's first name, the first six characters of the claimant's last name, and the claimant's birth date and gender.[7] CMS' system must find an exact match of the submitted SSN or HICN. Thereafter, at least three out of the four remaining informational elements must yield an exact match.[8]

As part of this process, claimant lawyers may be noticing increased discovery requests seeking their client's SSNs (or requests to confirm the accuracy of the SSN that the RRE may already have on file) and for other related information. On the flip side, defense counsel may be finding that their clients are requiring them to request this information as part of their standard discovery practices. This may include forwarding CMS' "model language" document (or a variation thereof) to the claimant. This document is essentially a questionnaire for the claimant's execution asking him/her to provide information that the RRE needs to determine the claimant's Medicare status. As general practice, defense counsel should consult with their clients to see how they could assist them in regard to this important Section 111 aspect.

All these efforts, especially the emphasis on obtaining the claimant's SSN, are aimed at helping the RRE determine the claimant's Medicare status via Query Process. Furthermore, in light of Section 111's significant penalty, claimant counsel may find that the RRE still wants this information in order to confirm the claimant's Medicare status through CMS' Query Process system, rather than relying on the claimant's representations regarding his/her status.

Query Process – Practical Realities

In the workers' compensation context, RREs are more likely to have access to the claimant's SSN as part of the underlying employment relationship, or have the ability to obtain same as part of standard discovery practice. By contrast, liability RREs typically do not have access to the plaintiff's SSN and they may experience resistance in obtaining same as this type of information is usually not freely exchanged as part of the liability discovery process.

In fact, cases have already started to surface on the liability side where the plaintiff has refused to provide the RRE with his/her SSN for Query Process purposes. In each of these cases the plaintiffs refused to provide their SSN primarily on privacy grounds, concerns that the requested information could be used for discovery purposes outside of Section 111, and technical arguments that the requests were not yet ripe under Section 111's reporting mandates.

However, in all three of these cases the courts ordered the plaintiffs to release their SSNs to the RRE. The courts ruled that the RRE needed this information to comply with Section 111, recognized the function of Query Process, and found that the requests were relevant under applicable discovery rules.[9]

When Are Claims Reportable Under Section 111?

RREs are required to report claims if they meet a Section 111 "reporting trigger." CMS has established two reporting triggers referred to as: **TPOC** (total payment obligation to the claimant) and **ORM** (on-going responsibility for medicals). Depending on the circumstances, reporting under both triggers may be required. The following is a very *general* overview of the TPOC and ORM triggers.

TPOC Reporting

Under the TPOC reporting trigger, reporting is required upon claim resolution (or partial resolution) through a settlement, judgment, award, or other payment for cases in which the claimant is/was a Medicare beneficiary as of the TPOC date and where medicals

were claimed and/or released, or the settlement, judgment, award, or other payment has the effect of releasing medicals.[10] For workers' compensation claims, reporting is required for TPOCs occurring on or after October 1, 2010 that exceed CMS' interim TPOC monetary threshold amounts.[11]

Per CMS' current workers' compensation TPOC monetary thresholds, TPOCs greater than $5,000 through the end of 2012 are reportable. In 2013, TPOCs greater than $2,000 are reportable, while in 2014 TPOCs greater than $600 become reportable. There are no interim threshold amounts starting in 2015.[12]

The "status" of the claim does *not* matter for Section 111 reporting purposes. Accordingly, TPOC reporting is required *"regardless of whether or not there is an admission or determination of liability."*[13] Thus, for example, a denied settlement (the settlement being a TPOC) involving a Medicare beneficiary is reportable, assuming that the settlement amount exceeds the applicable TPOC monetary reporting threshold. Likewise, the allocation of settlement proceeds, whether by the parties or by the court, does *not* affect Section 111 reporting obligations.[14]

ORM Reporting

Under the ORM reporting trigger, reporting is required when the RRE assumes "on-going responsibility for medicals" on or after January 1, 2010 (and in certain cases where the ORM pre-dates January 1, 2010), and the claimant is a Medicare beneficiary upon the assumption of ORM, or becomes a beneficiary at any time during the ORM period.[15]

If the claimant is *not* a Medicare beneficiary when ORM is assumed, the RRE is obligated to monitor the claimant's Medicare status. If the claimant subsequently becomes a Medicare beneficiary at any point during the ORM period the RRE then must report the claim.[16] Through the end of 2012, there is a $750 ORM reporting threshold for certain workers' compensation claims.[17]

In general, ORM is assumed when the RRE *"has made a determination to assume responsibility for ORM or is otherwise required to assume ORM, not when or after the first payment for medicals under ORM has actually been made."*[18] Payments made during an investigatory period may constitute ORM.[19] This could have particular relevance in relation to Florida's 120 day rule.[20] Also, the fact that a RRE considers a claim dormant or administratively closed does not necessarily mean that ORM reporting is not required, or that the RRE may terminate an open ORM report.[21]

General Reporting Matters

Regarding what information must be reported, there are over 140 potential data fields which may need to be transmitted. The number of reportable data fields varies depending on the particular circumstances of each case. It may be worthwhile for defense counsel in particular to become familiar with CMS' various record layouts to get a sense of the type of information that needs to be reported.[22]

Examples of some of the more basic information that is typically reportable includes: claimant's information (name, DOB, SSN, gender); date of accident (as defined by CMS); claim type; insurance type/policy information; TPOC date/amount; ORM assumption/termination date; claimant lawyer information (including the claimant lawyer's federal tax identification number); and related ICD-9 codes.[23]

In regard to gathering the reportable data, most RREs have built computer programs and instituted internal measures to "capture" this information as part of the claim process. There may, however, be some circumstances where counsel may be asked to assist in obtaining necessary information. Defense counsel may want to check with their clients to see how they may be of assistance to them in obtaining the information that needs to be reported.

Likewise, RREs or their agents have developed internal systems to identify when reporting is required and for the electronic transmission of required Section 111 report(s) to CMS. Thus, unless the workers' compensation lawyer (or his/her firm) is a registered Section 111 agent (which will be a rare situation), counsel will play no role in the actual "button pushing" aspect of the Section 111 reporting process. This will be done by the RRE or its agent.

When the Dust Settles

As the pieces fall into place, workers' compensation practitioners will likely find that they have a limited, but important, role in the overall Section 111 process. Regardless of the extent of this involvement, it is important for counsel to have a fundamental understanding of the larger compliance activities in motion around them during the course of the claim.

For claimant's counsel, knowledge of Section 111 may help make sense of why they may be receiving increasing requests for their client's personal information, and help explain the primary payer's overall heightened sensitivity to addressing Medicare's interests in general. For defense counsel, knowledge of Section 111 is important in terms of better understanding how certain facts (e.g. claimant becoming a Medicare beneficiary), or claim events (e.g. a decision to pick up a claim compensable, reaching a settlement, etc.) could trigger Section 111 compliance obligations for their clients.

As part of this overall process, it is also important for counsel to keep Section 111 in proper perspective. Section 111 represents only *one* aspect of MSP compliance. It simply involves the electronic reporting of claims to CMS. Section 111 does _not_ address compliance obligations pertaining to conditional payment reimbursement or Medicare set-asides (MSAs).[24]

Whether or not Section 111 reporting is required, not yet ripe, or exempted altogether is totally independent from MSAs and conditional payments under the MSP. These compliance obligations involve *separate* requirements and *different* reporting obligations. In relation to same, counsel need to work with their clients to ensure that they are properly and timely addressing MSA and conditional payment reimbursement issues – regardless of what may or may not be required by Section 111 and who is handling the reporting aspect of the claim.

With Section 111 placing more cases than ever on Medicare's radar, the agency now has a bird's eye view into claims. As CMS' compliance bull's eye widens, assuring that Medicare's interests are being properly protected is now taking on even greater significance and should be a major focus for all workers' compensation practitioners.

Conclusion

Going forward, Section 111 reporting will continue to have a significant impact on claims practice as part of CMS' larger MSP enforcement efforts. As CMS continues to tighten its compliance grip, it is imperative that counsel have working knowledge of Section 111's requirements, how they fit into the overall process, and, importantly, how they could be of assistance in facilitating compliance with the reporting mandates.

Mark Popolizio, Esquire *is Section 111 Senior Legal Counsel for Crowe Paradis Services Corporation. Mark is a nationally recognized authority in MSP compliance. He has authored numerous articles on MSP issues including MMSEA Section 111, MSAs and conditional payments. Mark is a regularly featured presenter at national seminars and other industry events. Prior to dedicating his practice to MSP compliance in 2006, Mark practiced workers' compensation and liability insurance defense for ten years representing carriers, employers, third party administrators and self insureds. Mark is based out of Miami, Florida and can be reached at mpopolizio@cpscmsa.com or (786) 459-9117.*

Endnotes:

1 The Medicare Secondary Payer Statute is codified at 42 U.S.C. § 1395y, et. seq. In addition, pertinent MSP provisions are contained in Subparts B, C, and D of Title 42 of the Code of Federal Regulations (42 C.F.R. §§ 411.20 through 411.50, et. seq.).

2 The Medicare, Medicaid and SCHIP Extension Act is codified at 42 U.S.C. § 1395y(b)(7) and (8). Subsection (7) concerns group health plans, while subsection (8) addresses reporting obligations in the non-group health context (e.g. workers' compensation, liability insurance, no-fault, med-pay, etc.). This article only addresses Section 111 reporting obligations with respect to non-group health plans.

3 *See*, CMS' *NGHP User Guide* (December 16, 2011) at 21-31.

4 *Id*.

5 *Id*. at 30.

6 *Id.*

7 *Id.* at 130.

8 *Id.*

9 *See*, ***Seger v. Tank Connection, LLC***, No. 8:08CV75, 2010 WL 1665253 (D. Neb. April 22, 2010), ***Hackley v. Garafano***, No. CV0905031940S, 2010 WL 3025597 (Conn. Super. July 1, 2010), and ***Smith v. Sound Breeze of Groton Condominium Ass'n, Inc.***, No. KNLCV095012261S, 2011 WL 803067 (Conn. Super. Feb. 3, 2011).

10 CMS' *NGHP User Guide* (December 16, 2011) at 48, 72 and 108.

11 The TPOC "date" is defined as follows:

Date payment obligation was established. This is the date the obligation was signed if there is a written agreement unless court approval is required. If court approval is required it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement it is the date the payment (first payment if there will be multiple payments) is issued. *Id.* at 9 and 191.

The TPOC "amount" is defined as follows:

Dollar amount of the total payment obligation to the claimant. If there is a structured settlement, the amount is the total payout amount. If a settlement provides for the purchase of an annuity, it is the total payout from the annuity. For annuities, base the total amount upon the time period used in calculating the purchase price of the annuity or the minimum payout amount (if there is a minimum payout amount), whichever calculation results in the larger amount. *Id.* at 192-193

12 *Id*. at 69. In relation to these thresholds, it is important to remember that same are governed by the TPOC "date" as defined by CMS. *See*, n. 11. Furthermore, in multiple TPOC situations CMS uses "the last (most recent)" TPOC date to determine when an applicable interim threshold is exceeded. *Id.*

With regard to *non-workers' compensation* cases, for **no-fault claims** reporting is required for all TPOCs occurring on or after October 1, 2010. There are *no* TPOC interim monetary reporting thresholds for no-fault cases.

For **liability claims**, reporting is required for all TPOCs occurring on or after October 1, 2011 which exceed CMS' liability TPOC interim monetary reporting threshold schedule as follows: TPOCs from October 1, 2011 through March 31, 2012 greater than $100,000 are reportable; TPOCs from April 1, 2012 through June 30, 2012 greater than $50,000 are reportable; and TPOCs from July 1, 2012 through September 30, 2012 greater than $25,000 are reportable. Thereafter, liability TPOCs from October 1, 2012 and forward are governed by the remaining TPOC monetary thresholds applicable to worker's compensation claims outlined *supra* at p. XXXX. *See*, CMS' *September 30, 2011 "Alert."*

13 CMS' *NGHP User Guide* (December 16, 2011) at 111.

14 *Id.*

15 *Id.* at 48 and 72. This ORM criterion is also applicable to no-fault and liability claims.

16 *Id.* at 100.

17 With respect to workers' compensation claims only, CMS has established a limited ORM "monetary" threshold for reporting. Under this exception, workers' compensation claims are *excluded* from ORM reporting if (a) the claim is for "medicals only," (b) involves "lost time" for no more than the number of days permitted by the applicable workers' compensation law for "medical only" claims (or seven calendar days if the law has no such limit), (c) all payment(s) has/have

been made directly to the medical provider; and (d) total payment for medicals does not exceed $750. *Id.* at 67-68. This threshold exception does not apply to no-fault or liability ORM reporting

18 *Id.* at 97.

19 *Id*. at 100.

20 Fla. Stat. § 440.20 (4) (2011).

21 CMS' *NGHP User Guide* (December 16, 2011, Version 3.3) at 99. On this point, the general rule is that ORM exists if the *"ORM is subject to reopening or otherwise subject to a further request for payment." Id*. at 99 and 102. However, CMS has created two exceptions to this general rule which either exempt ORM reporting in the first instance, or permit the RRE to file an ORM termination report with respect to an open ORM report. These exceptions are referred to as "Qualified Exception" and "Special Exception."

CMS' **Qualified Exception** relates to older claims where ORM was assumed prior to January 1, 2010. In regard to these claims, CMS exempts reporting *"if the claim was actively closed or removed from the current claims records prior to January 1, 2010."* Id at 102.

Under CMS' **Special Exception,** CMS permits the RRE to terminate an open ORM report in relation to claims where *"as a practical matter, there is no possibility of associated future treatment"* if the RRE obtains a *"signed statement from the injured individual's treating physician that he/she will require no further medical items or services associated with the claim/claimed injuries, regardless of the fact that the claim may be subject to reopening or otherwise subject to a claim for further payment." Id*. at 100. It is important to note that in either scenario if there is subsequent reopening of the claim and further ORM, the RRE must report the claim.

22 *See,* CMS' *NGHP User Guide* (December 16, 2011, Version 3.3) Appendices A-D at 164-260.

23 *Id.*

24 *Id.* at 10.

Friends of 440 Scholarship Welcomes You!

The Friends of 440 Scholarship Fund, Inc. is a 501(c)(3) charitable organization whose membership is comprised of attorneys, doctors, insurance adjusters, Judges of Compensation Claims, claims administrators, rehabilitation providers and others whose primary employment is connected within Florida's Workers' Compensation system. Throughout the year we put our differences aside and raise scholarship funds to aid students who lack the economic ability to continue their education beyond high school or to further their college education.

The Friends of 440 Scholarship Fund, Inc. has been in existence since 1991 and over the course of the past 18 years has raised almost $1 million which has been used to assist over 518 qualified college students achieve their educational goals.

During the 2009-2010 selection scholarship process, The Friends of 440 Scholarship Fund, Inc. proudly announced the award of over $73,000.00 in scholarship funds to 43 applicants throughout the State of Florida.

The number of scholarships awarded each year is directly related to the amount of funds available. Therefore, fund-raising is an important activity for this non-profit corporation. Various fund raising projects are undertaken each year throughout the state of Florida. Corporate and individual donations are welcomed, and are tax-deductible.

Our Mission Statement

To aid dependents or descendants of workers who are injured in the course and scope of their employment and receive benefits under the Florida Workers' Compensation Law and who reside or whose accident occurred in the State of Florida. Applicants must not be related directly or indirectly to any member of the Board of Directors. Furthermore, dependents or descendants of individuals who primarily engage in the operation and/or administration of the Florida Workers' Compensation Law are eligible to receive the scholarship on a statewide basis. This scholarship is intended to aid students who lack the economic ability to continue education beyond high school or to further their college education. Applications must be submitted prior to February 28th, of the year the scholarship is to be awarded.

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We welcome your donations and your feedback! The location of our headquarters is: The Friends of 440 Scholarship Fund, Inc., 9350 South Dixie Highway, 10th Floor, Miami, FL 33156-2900

Scholarship applications are available as a pdf at http://www.440scholarship.org/the-scholarship/application.

FRIENDS OF 440 SCHOLARSHIP FUND, INC.

STATEMENT OF PURPOSE, GUIDELINES & APPLICATION

To aid dependents or descendants of workers who are injured in the course and scope of their employment and receive benefits under the Florida Workers' Compensation Law and who reside or whose accident occurred in the State of Florida. Applicants must not be related directly or indirectly to any member of the Board of Directors. Furthermore, dependents or descendants of individuals who primarily engage in the operation and/or administration of the Florida Workers' Compensation Law are eligible to receive the scholarship on a statewide basis. This scholarship is intended to aid students who lack the economic ability to continue education beyond high school or to further their college education. Applications must be submitted prior to February 28th, of the year the scholarship is to be awarded.

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COMPLETED APPLICATIONS MUST BE MAILED TO THE FRIENDS OF 440 SCHOLARSHIP FUND INC., 9350 SOUTH DIXIE HIGHWAY, 10TH FLOOR, MIAMI, FLORIDA 33156-2900 TELEPHONE NUMBER: (305) 671-1300

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Please submit the following documents with this application (photocopies only):

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1. Mandatory – Copy of most recent tax return of parent and/or guardian
2. Mandatory – Copy of applicant's most recent school transcript
3. If applicable - Copy of applicant's most recent tax return

Applications will NOT be processed
if ANY of the above documents are missing

Complete scholarship applications are available as a pdf at http://www.440scholarship.org/the-scholarship/application.

Where Do You Draw The Line?

By Mark Zeintz, Esq., Miami, FL

The "line" is the divider between a constitutional workers compensation scheme and an unconstitutional workers' compensation scheme based upon the adequacy of the benefits provided by the act. The constitutionality "line" of the workers' compensation scheme has been defined as that point below which the benefits of the scheme are no longer an "adequate replacement for the tort remedy" citation. The "line" has also been defined as that point below which the scheme is no longer the "preferable safeguard" and no longer the "the least intrusive way" to handle claims for injury on the job. The "line" has also been set at that point below which collecting on claims is not "certain" and "fast".[1] One need not go back to 1935, the year Florida first passed a workers' compensation act because the scheme was not really totally exclusive and mandatory until the legislature repealed the "opt out" provisions in 1970. Up to 1970, an employee could "opt out" of coverage under the act. We do need to remember that the act was ingrained in our legal system as of the promulgation of the Constitution of 1968 and the enactment of the Declaration of Rights, which included the "inviolate" right to trial by jury, access to courts and the right to be rewarded for industry.

After the Constitution of 1968 became effective, did the repeal of the "opt out" provision cross the line? Or did the transformation of the Tort system from one using contributory negligence to one using comparative negligence in 1973, as described in *Hoffman v. Jones*, cross the line?[2] Remember, workers' compensation was the replacement for the tort remedy that had the value of any negligence claim that could be defeated by proof that the injured worker was only 1% contributorily negligent, or assumed the risk of a hazardous job, or was injured in whole or in part by the negligence of a fellow servant. All that changed in 1973. The value of the injured workers claim in tort went up exponentially. Without a significant increase in workers' compensation benefits to account for the change in the value of the replacement remedy, was the line crossed?

The 1972 report of the National Commission on State Workmen's (sic) Compensation Laws was prepared by a commission as required by the 1970 OSHA.[3] The OSHA, passed during the Nixon administration had an edict to study the *adequacy* of State workers' compensation acts. The commission consisted of stakeholders from all concerned entities including the insurance industry, academia, unions, employers and state boards. The commission's report was unanimous. It concluded in the cover letter to the President and Congress dated July 31, 1972, "We also agree that the protection furnished by workmen's (sic) compensation to American workers presently is, in general, *inadequate and inequitable*. Significant improvements in workmen's (sic) compensation laws are necessary if the program is to fulfill its potential." The cover letter was signed by John F. Burton, Jr. Chairman.

In its report the Commission set up 19 "essential recommendations" for State laws. Of the 19 essentials, Florida had only 6.5 in 1972. After the 2009 legislative session, that total went down to 5.5. with the elimination of some rights to file claims in other jurisdictions. Florida in 2011 has only 28% of the 19 essentials determined in 1972! Is this where the line was crossed?

The report concluded, "We are without exception supporters of the basic principles of workmen's (sic) compensation. We have criticized the present State workmen's (sic) compensation programs, but not because we believe the basic principles are inherently wrong. Indeed they are right. We voice our criticism because the *present practice falls so far short of the basic principles, and because there is no possible justification for this short-fall."* The Federal Government concludes the line has been crossed in 1972!

You ask, "Who was on this commission that damned the workers' compensation schemes of the states as inadequate and inequitable in a unanimous report?" Here are a few of the members who would be least likely to endorse the conclusion: Clarence E. Carothers, Ford Motor Co., William J. Moshofsky, V.P. Georgia-Pacific Corp., Melvin B. Bradshaw, Exec. V.P. Liberty Mutual Ins. Co. Big business and Insurance agrees, the line has been crossed.

It would seem that the "line" of adequacy had already been crossed in 1972. Are benefits better in Florida since 1972? Examination of benefits in comparison to the 1972 act will reveal some changes that could be considered improvements. Further examination puts even these in question. For example, in 1972 (as in 1968), the weekly compensation rate was computed by calculating 60% of the Average Weekly Wage (AWW) and was limited (capped) at 66 2/3 % of the statewide AWW (the maximum compensation rate, as of June 30, 1972 was $66.00 per week). Effective October 1, 1974 the compensation rate was computed by calculating 66 2/3 of the AWW and the cap was 100% of the Statewide AWW. Seemingly an increase. Look further. Since 1974 the AWW calculation has been severely limited. Whereas in 1974 the AWW included the fair market

value of all fringe benefits and tips, as of 2011 the AWW only includes gross pay plus the employer contribution to health insurance (if and when the contribution ends) and in rare instances, the cost to the employer of housing. Tips, to be included in the AWW have very strict reporting requirements, often not met by tipped employees. Eliminated over the years are the value of company cars, cell phones, free or reduced rate meals, pension contributions, overnight lodging, free or reduced rate parking, gifts, and other similar advantage. The end result for many employees is a reduction in the AWW and the compensation rate. Anyone who earns more than the amount sufficient to reach the statewide maximum gets no compensation for that loss. The National Commission report recommended that the limit be 200% of the statewide AWW. Does this defect cross the line?

Florida Supreme Court Justice Richard W. Ervin (Retired), in a 1986 speech to the Judges of Industrial Claims (now Judges of Compensation Claims) compared worker's benefits pre 1979 with post 1979 benefits (The Wage Loss System introduced at the request of industry in 1979 became defunct as of July 1, 1990). Justice Ervin commented:

> "Frankly, I am quite unable to say whether workers fare better now (1986) than they did in 1978".

In 1972 an injured worker could count on being provided full medical care and temporary indemnity while recuperating from the injury. Temporary Total Disability (TTD) and Temporary Partial Disability (TPD) benefits were authorized by Florida Statute 440.15 to be paid for up to 12 years. A claimant who needed vocational rehabilitation could get up to an additional 52 weeks of TTD for rehabilitation. 13 years in all. As of 2003 that total has been reduced to 104 weeks (2 years) of TTD/TPD and Rehabilitation. A reduction of 85%. A very recent en banc decision of the First District Court of Appeal in *Matrix v. Hadley*[4] seemed to indicate that the court felt it was not charged with the responsibility of determining the *adequacy* of the exclusive replacement remedy, that it was OK to stop all indemnity payments to injured workers after 104 weeks of indemnity benefits even if the employee remained totally disabled and in need of remedial medical care. The dissent pointed out the unconstitutional nature of the effect of the decision. So a large minority of the First DCA (6 Judges out of 15) has found the line has been crossed in this decision and in others.

Full medical care is also a thing of the past, even if the Supreme Court in *Martinez v. Scanlan*,[5] said in 1991 that without full medical care the statute is unconstitutional. As of January 1, 1994 every employee who had reached Maximum Medical Improvement (MMI) was required to pay a $10.00 co-payment to see the doctor even if it was necessary to continue to get prescribed medication of the type that needed a doctor visit every month. As of 2003, all medical must be apportioned with the employee paying that part of the bill that is related to a pre-existing non-work related condition. If the employee has no money, he gets no medical care even if the employer is 99% responsible! The Florida Supreme Court in *Martinez* has indicated the 2011 act is unconstitutional and the line has been crossed.

In 1972 Permanent Total Disability (PTD) was paid for life. As of 1974 lifetime PTD benefits were supplemented by a 5% yearly increase for cost of living. But as of 2011, PTD is paid only up tp age 75 or 5 years (whichever is greater) and the supplements that were reduced to 3% in 2003 stop altogether at age 62. PTD which in 1972 was paid if the injured worker could not return to uninterrupted work that was light or sedentary, can only achieve PTD status in 2011 if unable to do any work at any rate of pay that might be available within 50 miles of the employees residence. Or the injured worker has to be catastrophically injured. Line crossed again!

In 1972 the act provided a benefit for loss of wage earning capacity, also called Permanent Partial Disability (PPD) if the amount of PPD exceeded the benefits allowable for Permanent Physical Impairment (PPI) the higher benefit was paid. Over the years both sides of the equation have changed. PPI is no longer paid based upon the learned opinions of the medical providers. In 2011 there is a Florida Guide that must be followed based solely on objective medical evidence to assign a percentage of PPI. If the injured worker suffers a career ending injury where he could previously earn $1,000.00 per week and has a 6% PPI from a herniated lumbar disc, that worker gets 12 weeks of Impairment Benefits (IB's) paid at either 37.5% or 75% of his compensation rate (37.5% of the comp rate is paid if working and earing the same or more than the AWW, 75% if not working[6]) and that is it. The injured worker who suffers a 50% reduction in his earning capacity gets nothing more than the 12 weeks of reduced benefits. There is no longer, as of 2003, any benefit in the law for loss of wage earning capacity of PPD. The $1,000.00 per week worker who returns to work and is only able to earn $500.00 per week loses $26,000.00 per year in income for which there is no compensation whatsoever. A whole classification of benefits for PPD has been eliminated without any benefit to take its place. According to the Supreme Court in *Kluger v. White, id.* such action by the legislature is a constitutional no no. This seems like an absolute line crosser.

Is there any good news? Yes. The death benefit was increased from $15,000.00 plus $500.00 funeral expenses in 1972 to $150,000.00 plus $7,500.00 for funeral expenses in 2011. Yet the bad news is that at the current maximum compensation rate all benefits for an entire family and all dependents of the deceased from prior marriages will be exhausted in 3.7 years. And the same maximum amount of benefits applies to the minimum wage earner or the executive.

I have not tried to cover all the examples of crossing the line as to benefits and I have stayed away from those

claims that are no longer covered or impossible to prove, ie: exposure cases.[7] The dissent by Judge Wolf said, "Accordingly, the majority decision (Judges Hawkes and Marstiller) founded on the absence of contemporaneous air-quality studies and a complete devaluation of the circumstantial evidence of record, has constructed a burden of proof for mold exposure claims which is artificial, illusory, and practically unachievable and represents a burden which far exceeds that imposed by the legislature". In other words, for an employee to prove injury on the job related to mold exposure the employee would have to have an air quality inspector tag along with him every day he goes to work.

I have chosen to avoid the issue raised by the introduction of the term "Major Contributing Cause" as it relates to compensability because I believe such a defense, if raised by the Employer/Carrier (E/C), estops the E/C from defending a tort action against the employer on the grounds of workers' compensation immunity.

I have avoided a discussion of attorney fees paid by the E/C for their failure to timely and correctly pay benefits which, by practice in the community, were 30% of the benefits obtained in 1972. They are now statutorily capped at roughly 10% or less of the benefits obtained. The attorney fee 'benefit' severely restricts an injured workers ability to obtain competent counsel while the E/C may spend unlimited funds to defend a claim. Lack of a level playing field in litigation is another line crosser.

One other area I have avoided discussing is the 2003 amendment which placed an additional roadblock and chilling effect on the filing of a claim by an employee. That is the risk that the employee might be responsible for the employers costs in the event the employee did not prevail. The failure of the employee to pay a costs order has been held to be a basis to dismiss pending and future claims. This issue is now on appeal in the Supreme Court and in the First DCA.

The line has not only been crossed, it has been obliterated. Why has there been no action by the Courts to correct these obvious wrongs? What drives the Florida legislature to decimate benefits? The National Commission, in 1972, gave us the answer. The "main barrier" to workers' compensation reform is the fear that compensation costs may drive employers to move away to markets where protection for disabled workers is inadequate but less expensive. Welcome to the inadequate but less expensive State of Florida, 2011.

__Mark L. Zientz__ is currently Chair-Elect designate of the Workers' Compensation Section of The Florida Bar. He is a current member and Past Secretary of the Executive Council of the Workers' Compensation Section of the Florida Bar, a former Vice-Chairman of the Worker's Compensation Rules Committee of the Florida Bar, an arbitrator for the National Football League Players Association / Management Council and the Arena Football League as well as a member of the faculty of the Workers' Compensation Trial Advocacy Seminar since the inception of the program. Mr. Zientz has also been a past President of the Friends of 440, Inc., where he remains on the Board. He is also a Director of the Friends of 440 Scholarship Fund, Inc., Mr. Zientz is the attorney responsible for handling the appeals in over 250 cases in which the appellate court issued a written opinion. Mr Zientz handled many of these cases at the trial level as well. Some of his appellate work has produced landmark cases such as Barrigan v. City of Miami, and more recently, Cagnoli v. Tandem Staffing, SRS Hartford and the Division of Workers' Compensation. Mark Zientz is admitted to practice law in three states and before the Supreme Court of the United States. Aside from Florida, where he currently lives and practices, he is also admitted to the bar in the State of New York where he served as a Kings County (Brooklyn) Assistant District Attorney from 1971 to 1974, and the State Bar of Montana, admitted in 1996. Mr. Zientz attended primary school in New York City, received his Bachelor of Science degree from New York University (1964), and then received his J.D. Degree from Brooklyn Law School (1971). In 1988 he became Florida Bar Board Certified in Workers' Compensation. He is rated Av by Martindale Hubbell. Mr. Zientz is a member of the board of directors of the Workers Injury Law & Advocacy Group (WILG) and Florida Workers Advocates (FWA). He has written extensively on the subject of workers' compensation for the News and 440 Report, The Florida Bar Journal and WILG's "First Watch". He has also prepared numerous Amicus Curiae briefs in the Florida Supreme Court and the First District Court of Appeal on behalf of WILG and FWA.

Visit YOUR Section website:

www.flworkerscomp.org

Endnotes:

1 *Sasso v. Ram Property Management,* 431 So. 2d 204 (Fla. 1 DCA 1983), *Kluger v. White,* 281 So. 2d 1, Fla. 1973, *DeAyala v. Florida Farm Bureau*, 543 So. 2d 204, 206 (Fla. 1989)

2 280 So. 2d 431 (Fla 1973)

3 http://www.workerscompresources.com/National_Commission_Report/national_commission-report.htmcitation/link.

4 Case # 1D09-3360 (Fla. 1 DCA November 29, 2011)

5 582 So. 2d 1167 (Fla. 1991)

6 See Section 440.15(3)(c), Fla. Stat. (2009)

7 Altman Contractors v. Gibson, 63 So. 3d 802 (Fla. 1 DCA 2011)

State of Florida
Division of Administrative Hearings
Office of the Judges of Compensation Claims
St. Petersburg District Office

Donna S. Remsnyder
Judge of Compensation Claims

Stephen L. Rosen
Judge of Compensation Claims

March 14, 2012

Dear Counselors and Staff practicing in the St. Petersburg District Office,

As you may have heard by now, The Honorable Donna S. Remsnyder, Judge of Compensation Claims, has graciously agreed to move to Melbourne/ Sebastian, Florida to take over the responsibilities of JCC in that district due to a vacancy. Her duties there are to begin April 2, 2012.

For the foreseeable future, the St. Petersburg District Office of the OJCC will perform its duties as a single judge District with the undersigned as the presiding judge.

All support staff and mediators currently assigned to the St. Petersburg District Office will remain in place.

Judge Remsnyder will take all of her currently assigned Lakeland and Miami cases with her to Melbourne/Sebastian as of April 2, 2012.

All other cases currently assigned to the St. Petersburg District, as well as new petitions filed after April 2, 2012 will be assigned to me.

All remaining active cases in our office, as well as those cases filed after April 2, 2012, will be designated as SLR but will be handled by staff on an alphabetical basis. Cases with the last name beginning with the letters A through L will be handled by Carol and Sheila, and M through Z will be handled by Wanda and Marilyn. Thus, all that you and your staff will have to do when you call into our office is to have the last name of the claimant so that you will be transferred to the appropriate support staff member depending on where the case falls in the alphabet.

The entire mediation alphabet will be handled by Louise.

We are expecting a smooth transition, but the entire staff, including myself, requests your cooperation, support and patience during this transition. The staff, or myself, will be happy to answer any questions that you have regarding this procedure throughout the changeover. However, in reality, all of the procedures that you are used to working with in the St. Petersburg District Office should remain the same; it will just be a single judge District.

We will attempt to schedule all of our final hearings easily within the 210 day statutory/procedural requirement. However, there may be some double bookings involved. If cases are double booked and go to trial at the same time, we will be requesting a visiting judge to participate through the video teleconferencing system. You may not be notified of this ahead of time. However, this should not be material as I am sure that your objective is to get your case heard for your clients, whether your client is the employee or the employer/carrier, on a timely basis.

The kinks in the transitional period will be worked out eventually, but in the meantime and as requested above, please give us your cooperation, support and patience during the process.

Very truly yours,

Stephen L. Rosen
Judge of Compensation Claims, St. Petersburg

Case Law Update

by Rogers Turner, Esq., Winter Park, FL

Preservation of Error

***Hawkins v. Publix Supermarkets/Publix Risk Mgmt.*, ___So.3d___(Fla.1st DCA 11/17/2011), on motion for rehearing**

The DCA withdrew their PCA opinion issued in August, and again affirmed the JCC's denial of benefits. However, the court wrote to clarify the JCC did not err in resolving conflicts in the medical testimony, and that claimant/ Appellant failed to preserve for appeal the issue he now raises about inadequate factual findings, citing *Hamilton v. R.L. Best Int'l* (holding if error is one that first appears in final order, aggrieved party must bring it to JCC's attention by filing motion for rehearing).

Appeals/Final Orders

***Eaton v. City of Winter Haven/PGCS*, ___So.3d___ (Fla.1st DCA 11/6/2011)**

The JCC awarded PTD, but appointed an EMA to determine the compensability of a claim for psychiatric treatment. As the Order did not dispose of all issues presented to the JCC, it was non-Final and not ripe for Appellate Review.

Independent Medical Examiners/ Binding Nature of IME opinion

*****Case argued at comp convention*****

***Keeton v. KFC/Gallagher Bassett*, ___So.3d___ (Fla.1st DCA 11/16/2011)**

The DCA affirmed the JCC's denial of compensability of carpal tunnel per the EMA's opinion. Although the authorized treating physician opined no MCC existed, the E/C's subsequently chosen IME felt that MCC did exist. The claimant appealed the appointment of the EMA, arguing the E/C was bound to their IME's opinion, per subsection 5(b) of the IME statute. The DCA noted the JCC correctly distinguished the *Dawson* case (*no conflict where authorized doctor only examined the wrist but the alleged conflict concerned the shoulder*). Here the authorized doctor examined all body parts in question. The court found the "bound by" language of 5(b) controlled the limits on how many IMEs a party may obtain, and did not affect the EMA issue. A concurring opinion noted that the disagreement in opinions was sufficient to trigger appointment of the EMA.

Statute of Limitations/Burdens of Proof

***Miranda v. Azul Plastering/The Hartford*, ___So.3d___(Fla.1st DCA 11/16/2011)**

The JCC denied all benefits based on the SOL defense. The DCA analyzed the shifting burdens in an SOL case. The burden of proof on the claimant is a preponderance of the evidence, unless the E/C has complied with both sections 440.185 and 440.055, in which case the claimant has a higher burden of proof – clear and convincing evidence. When a claimant proves estoppel by preponderance of the evidence, the burden shifts to the E/C to show the claimant "had actual knowledge" of the limitations period. It was uncontested that the E/C did not provide notice in accordance with section 440.185; therefore, the appropriate standard of proof for the Claimant to establish estoppel is preponderance of the evidence. The JCC here applied the standard of clear and convincing evidence anyway. The E/C conceded that was error, but asserted it was harmless because the E/C proved, and the JCC found, Claimant had actual knowledge of the statute of limitations. The DCA found the JCC based that conclusion on several erroneous findings: that the E/C mailed notice of the statute of limitations to a Miami address in 2009; that Claimant had moved away from that mailing address at some earlier point in time; that the mailing was not returned as undeliverable; and that Claimant's mail was, for a time, forwarded from that address to Claimant. As it was not clear the mailing was forwarded to Claimant, those findings were insufficient, as a matter of law, to establish actual knowledge. The DCA re-

manded for application of the correct standard of proof and, if necessary, clarification of findings concerning the change in Claimant's residency.

PTD Benefits / "Temporary PTD"

***Matrix Employee Leasing/ First Commercial Claims v. Hadley*, ___So.3d___(Fla.1st DCA 11/29/2011)**

The DCA, in a 27 page opinion, with lengthy and impassioned dissents by Judges Padovano and Van Nortwick, reversed a JCC's award of "temporary" PTD benefits, finding such benefits do not exist in Chapter 440. The E/C paid 104 weeks of temporary benefits, as well as impairment benefits. The claimant, facing a surgical recommendation, then filed for PTD. The JCC considered the treating doctor's testimony, which did not state what the claimant's disability status would be upon reaching MMI. The doctor testified it was likely the claimant could work light duty upon reaching MMI. The JCC acknowledged the statute does not provide for "temporary PTD", but felt that the legislature could not have intended that a claimant would be left without benefits where his temporary benefits have expired, but where he has not reached overall maximum medical improvement. The DCA analyzed the PTD statute, as well as their prior decision in *Oswald*, which sought to deal with the "gap" period, and established the rule that the claimant who is not at MMI following expiration of the 104 weeks must present evidence that total disability will exist and remain after MMI.

Judge Padovano, the only current judge on the bench when the court issued *Oswald* (and from whose concurring opinion the majority quoted) argued at length that the statute can be read to provide for temporary PTD. He asserted that "when these statutes are read together, as they should be, it is clear that an injured worker who is still totally disabled at the end of the maximum period of eligibility for temporary total disability benefits is deemed to be at maximum medical improvement, regardless of any potential for improvement." Because the doctor is required by section 440.15(3)(d) to assess and certify the injured worker's "permanent impairment, " it follows that the permanent impairment rating that must be given at that time is the legal equivalent of a medical finding that the worker has reached maximum medical improvement. Judge Padovano further reasoned that it is true that the Legislature placed a fixed time limit on the right to recover temporary disability benefits, but the purpose of this time limit was not to create a gap in which a totally disabled but still improving worker will be uncompensated. To the contrary, it is clear from the overall statutory scheme that the time limit was designed as a deadline, to force the parties to make a relatively prompt decision about the need for permanent total disability benefits.

He stated that if the majority is correct, there could be a gap for an indefinite period of time, during which an injured worker is not compensated at all, even though there is no dispute that the worker is totally disabled. A disabled worker who has exhausted the 104 weeks of temporary benefits but who has still not fully recovered from the workplace injury might have to wait months or perhaps years before disability benefits would resume, even though the employee remains totally disabled all the while. By accepting this result, the majority has effectively concluded that a law designed to provide compensation to injured workers actually denies compensation to some injured workers. In effect, the majority has decided that the law does not provide benefits, much less the "prompt delivery of benefits," to injured workers like the claimant in this case.

Judge Van Nortwick dissented and made several cogent observations, noting that in the case of a totally disabled claimant whose rights to temporary disability benefits has expired, but who is prohibited from receiving permanent disability benefits, the elimination of disability benefits may reach a point where the claimant's cause of action has been effectively eliminated. In such a case, the courts might well find that the benefits under the Workers' Compensation Law are no longer a reasonable alternative to a tort remedy and that, as a result, workers have been denied access to courts. He urged the legislature to address this inadequacy under the Workers" Compensation Law. This seems to be a recurring theme, as these same statements have been made by judges in dissenting opinions in other recent cases.[1]

Defenses to Payment of Temporary Partial Disability Benefits/Failure to File DWC-19s

***Rucker v. Just Brakes/The Hartford*, ___So.3d___ (Fla.1st DCA 12/2011)**

The DCA reversed and remanded the JCC's denial of penalties and interest. The JCC awarded a majority of temporary partial disability benefits claimed, but denied penalties and interest. The DCA noted that the E/C did not assert at trial that the claimant failed to provide required evidence of establishment of earning capacity. The statute indicates that such failure by the claimant "shall" result in a suspension or nonpayment of TPD until the proper notification is provided. The DCA held the JCC committed error in ruling upon the affirmative defense of failure to provide DWC-19s, depriving the claimant of an opportunity to provide evidence of her entitlement to the "awards". The court found that as the claimant proved entitlement to temporary benefits it was error to not award the attendant penalties and interest.

DWC-19s/Carrier's Ability to Suspend Benefits where PTD adjudicated

***Glinski v. Pan Am Bank/CNA*, ___So.3d___(Fla. 1st DCA 12/9/2011)**

Claimant had been receiving PTD benefits since 1990. In August of 2009, the E/C sent the claimant DWC

-19 forms for the period of 11/07 through 8/26/09. The claimant ultimately returned the forms on 9/22/09, but with missing information. After requesting the forms be properly completed and not receiving a response, the carrier cut off the claimant's benefits on 12/21/09, and did not reinstate them until the claimant submitted the properly completed forms on 1/15/10. The claimant then sought payment of PTD for the period where the carrier refused to pay her PTD, arguing the failure to return the properly executed forms was not "willful" per the statute, and that the carrier may not suspend the claimant's benefits where there has been an order adjudicating PTD. The DCA affirmed the JCC as to both arguments. They found the JCC was correct in finding the claimant's excuses insufficient to overcome evidence of willful non-compliance. Further, the DCA noted that the statute was clear and unambiguous that the carrier need not seek judicial approval to suspend benefits, regardless if the benefits were previously awarded by judicial determination.

Temporary Indemnity/Penalties and Interest

Ballard v. Helms Designs/Amerisure, **___So.3d___ (Fla.1st DCA 12/30/2011)**

The claimant was awarded TPD for a certain period. The claimant then sought TPD for a different period, but the evidence showed the claimant was placed only on TTD for that period, but collecting unemployment. The JCC determined that the $87.05 in penalties and interest for the first period should be offset from the overpayment made by the carrier during the period the claimant collected unemployment (citing 440.34(3)(b)(2008) (*which precludes receipt of PTD or TTD during periods where the claimant collects UC benefits*) . The DCA reversed, finding that the carrier did not timely assert a right to the overpayment until the written closing argument after the close of evidence in the Merit Hearing. The DCA ordered payment of the $87.05, and awarded entitlement to attorney fees and costs for that benefit.

WC Immunity/Related Entities/ Employer Premises

Pensacola Christian College/Maddox v. Bruhn, **___So.3d___(Fla.1st DCA 12/30/2011)**

The circuit court denied the defendant college's motion seeking summary judgment based on WC immunity. The plaintiff, a full time student, was hired by PCC under an hourly work contract, which indicated she might be placed in employment with "any affiliate of PCC". She then began working for a bookstore on campus. She was injured when hit by a PCC van while she rode her bicycle back to the bookstore from a lunch break. The injury was reported to PCC's carrier, who had purchased a policy which included the bookstore and all campus affiliates. The circuit court based its denial of summary judgment on the facts that the plaintiff worked for a separate "legal entity" and that the injury did not occur on the premises of the bookstore. The appeals court analyzed immunity under the separate questions of whether the plaintiff was an employee of PCC and whether her injury occurred in the course and scope of employment. The DCA rejected the court's reasoning that she was not an employee of PCC (because her W-2 indicated she was an employee of the bookstore), noting that of the "special employer" factors, wages are the least important. Finding she was an employee of PCC, the DCA then determined that her injury on the premises of PCC occurred in the course and scope of her employment, and remanded the case for the circuit judge to enter an Order for the Defendant(s) awarding Summary Judgment on WC Immunity.

Temporary Indemnity/Period to Timely Pay Penalties and Interest

Perry v. Ecolab, Inc./Broadspire, **___So.3d___(Fla.1st DCA 1/13/12)**

The DCA reversed a denial of penalties and interest, holding the JCC erred in determining when such payments are due following rendition of an Order. The JCC awarded PTD benefits in an Order dated November 5th, 2010. The carrier paid the past due penalties and interest on November 24th, 2010, and the past due PTD benefits two days later. Although F.S.§ 440.20(7)(2002) indicates payments per an award are "due" within seven days after the Order is sent to the respective parties, the JCC improperly considered the time period in which an Order becomes "final" (30 days, absent appeal within that time) in finding no penalties and interest due for late payment. As the carrier issued payment past the period when they became due, the court remanded for entry of an order awarding penalties and interest, and any attendant additional costs and attorney fees.

Due Process

Moya-Perguero v. Trucks and Parts of Tampa, Inc./ Ameritrust, **___So.3d___(Fla.1st DCA 1/24/2012)**

The DCA reversed the JCC's Order dismissing the claimant's PFB, as the parties appeared for a hearing solely on the issue of Sanctions in the form of Attorney Fees. Parties are entitled to notice of the issues to be determined. The E/C confessed the JCC's error immediately in a single page answer brief, which foreclosed fees for the claimant's appellate attorney, who wrote a 40 page brief after the E/C confessed error.

Modification of Orders-Statutory Standard

AMS Staff Leasing, Inc./Brite Top Roofing et al. v. Giraldo, **___So.3d___(Fla.1st DCA 1/24/12)**

In September of 2008, the JCC awarded the claimant TPD benefits, but reduced that award based on wages

paid in lieu of compensation by the employer for a four month period of $500 per week. That Order was affirmed without opinion in 2009. At a hearing in 2011, the claimant sought to modify the prior Order, alleging that the JCC "overlooked" employer testimony in the 2008 proceeding that the claimant never received the checks issued by the employer. The JCC granted claimant's motion, and ordered TPD to be paid without the previously awarded credit. The DCA reversed this finding, noting that modification of a prior Order under F.S. 440.28(2006) must not only be based upon a "change in condition or¼a mistake in determination of fact", but also that such a mistake could not have been discovered at the time of the original proceeding and entry of the original order. Here, although the JCC apparently did overlook the evidence presented initially, both parties were aware the claimant failed to pick up the checks issued by the employer at the original trial, and claimant's proper remedy was to file a Motion for Rehearing.

EMA Standard/Repetitive Trauma/MCC

Federal Express Corp./Sedgwick CMS v. Lupo,___ So.3d___(Fla.1st DCA 1/24/2012)

The DCA reversed the JCC's Order in part, which awarded compensability and continuing medical care, finding the JCC improperly rejected the EMA's opinion regarding ongoing MCC of the claimant's ankle complaints. The claimant fractured his right ankle in 1987 and began working for the employer as a driver two years later. In 2001 he sought treatment for right ankle complaints, and received a referral to a podiatrist in 2003. After filing a PFB for compensability and authorization of the podiatrist, the parties eventually presented those questions to an EMA. The JCC found the EMA testified the claimant aggravated his pre-existing ankle condition, and that the IA was the MCC of the need for ongoing treatment. The DCA reversed and remanded, noting that the JCC improperly rejected the EMA's opinion that the MCC for ongoing treatment was NOT the IA. The court failed to find the requisite clear and convincing evidence to do so in the records. The Court disagreed with the JCC's assessment that the EMA was confused on this issue of ongoing treatment, noting she clearly stated her opinion. The DCA rejected the JCC's reliance on *Delgado*, noting in that case the evidence supported only a finding that the employment aggravated an underlying condition. The DCA found *Delgado* did not allow the JCC to reject the EMA's testimony that the MCC of the need for ongoing care for the right ankle complaints was the pre-existing condition.

Apportionment/Prior Work Related Injuries

Newick v. Webster Training Center/Zenith Ins. Co.,___So.3d___(Fla.1st DCA 2012)

The First DCA affirmed the JCC's Order finding the E/C was entitled to apportion 35% of the claimant's need for shoulder surgery to prior injuries/conditions. Before sustaining her 2010 compensable shoulder injury, the claimant had three shoulder dislocations. Although those injuries occurred while working for herself or others, the injuries were never reported or treated as WC claims, but rather paid through health insurance or out of pocket. The JCC allowed apportionment, based on the EMA opinion that only 65% of the need for surgery was due to the 2010 accident, and that the prior injuries were "never claimed or treated as compensable injuries", citing *Staffmark v. Merrell*. Claimant argued *Merrell* warranted reversal, regardless of whether the prior workplace injury was compensable or not. The DCA rejected this reasoning on multiple grounds. Neither *Merrell* (nor the prior *Proctor* or *Pearson* cases upon which *Merrell* relied), dealt with workplace injuries that were not claimed through WC. The DCA also held that claimant's argument would render the apportionment statute meaningless, and noted that the "industry should bear the burden" language of recent cases would not make sense if the prior work related injury were not a WC claim.

Judge Thomas' concurrence echoed the defense arguments that Merrell and Pearson were incorrectly decided. He noted that those opinions have mistakenly applied the definition of preexisting condition in allocation of benefits (i.e. fights between carriers) to apportionment (i.e. what percentage a carrier may ultimately assign to a claimant's pre-existing injury). The distinction is critically important, as the concepts are totally different, and there is no statutory exclusion for compensable work related injuries in the apportionment context.

Statute of Limitations/Tolling

Longley v. Miami Dade County School Board/ Gallagher Bassett Svcs, ___So.3d___(Fla.1st DCA 2/2/2012)

The DCA reversed the JCC's Order finding the SOL tolled for the claimant's 3/3/10 PFB. Unfortunately, the confusing opinion omits a key fact contained in the Merit Order on appeal (see OJCC Website). The Order states the claimant filed a PFB on 3/30/09 for a return to an authorized doctor. The carrier agreed to this and scheduled an appointment for 4/24/09. The opinion merely states the claimant "attended" the appointment. Only after one reads the underlying Order, however, do we learn the omitted facts; that the claimant appeared at the doctor's office, had words with the doctor, was never actually examined, nor did the doctor bill for the visit. The JCC below found this visit did not constitute "treatment", which would toll the statute. The parties were supposed to appear for mediation in July, however the claimant attorney wrote a letter on 7/22/09 stating that the 3/30/09 PFB is dismissed EXCEPT as to attorney's fees "over which the JCC retains jurisdiction." The claimant then subsequently filed a PFB on 3/3/10 which sought an alternate doctor or return to the doc-

tor the claimant was scheduled to see on 4/24/09. At that time the E/C raised the SOL defense, asserting the 3/30/09 PFB had been dismissed, and the appointment of 4/24/09 did not toll the statute. The DCA ruled the JCC erred in finding the '09 PFB dismissed, as the 7/22/09 letter "dismissed" everything except fee claim which was still pending as of the time the 3/3/10 PFB was filed. As such, the E/C did not have a valid SOL defense.

Attorney fee and costs claims that remain "pending" or unresolved following resolution of the indemnity or medical claims on a PFB do toll the SOL for the claimant. If agreeing to resolve "issues" but reserving or allowing fee and costs issues to remain, the recommended practice would be to shortly thereafter file a motion under FL.R W.C.P. 60Q-6.107, which allows an E/C to ask the JCC to require the claimant to file a verified motion for attorney's fees and costs and adjudicate the pending fees and costs. If this is not done, the PFB remains pending and the SOL cannot run.

Average Weekly Wage

***Gillislee v. EMI Enterprises, Inc., and Amtrust North America of Florida*, No. 1D11-2918 (Fla. 1st DCA Feb. 2, 2012).**

The DCA remanded the JCC's determination of the AWW and affirmed the denial of TTD/TPD. The DCA affirmed the JCC's denial of TTD/TPD based only upon an adjuster's testimony without medical evidence. The JCC had also excluded vacation and funeral pay actually paid to the claimant in the 13 weeks before the accident based upon Muscanell (vested sick pay not included in AWW). The DCA distinguished the case and instructed the JCC to determine if the vacation and funeral pay was includable.

Managed Care/Medical Benefits

***McNealy v. Verizon/Sedgwick Claims #1/AIG Claims #2,*___So3d___(Fla.1st DCA 2/9/12)**

The JCC reversed the JCC's Order denying the claimant a change in PCP and attorney fees and costs. Claimant changed from her initial orthopedist to an alternate, and continued to treat with the alternate ortho. She then filed a PFB seeking authorization of a primary care provider. The JCC accepted the E/C argument that the alternate ortho was an authorized provider and a PCP, and authorizing another doctor as PCP was redundant and unnecessary. The DCA analyzed F.S. 440.134 (2000) and the applicable F.A.C. Rule, and reversed. They held that the claimant in a managed care case is entitled to a PCP and to select a change in PCP from the managed care network, that the claimant did not have to establish medical necessity to obtain this benefit, and that the claimant was entitled to fees and costs for obtaining the change.

Temporary Total Disability/Evidentiary Standard

***Urquiza v. Greene Poultry/C&I Ins./Chartis,*___So.3d___(Fla.1st DCA 2/14/2012)**

The 1st DCA reversed the JCC's denial of a closed period of TTD. The E/C authorized psychiatric treatment for the claimant. That doctor placed the claimant on a no work status, which continued after the claimant left the employer. The E/C authorized a second psychiatrist, who agreed with the TTD opinion, specifically for a period from 9/15/10 to 11/23/10. The adjuster admitted that she received no medical records changing the claimant's status during that time from TTD to TPD. However, following a conference between the E/C attorney and the first psychiatrist, the adjuster received a confirming letter from the psychiatrist indicating that the status changed to TPD. The JCC sustained the claimant's objection to admissibility of the letter, but apparently used the facts in that letter to find the claimant was informed of the change, and therefore not credible. The DCA noted that where the claimant presents evidence of TTD status, the burden shifts to the E/C to provide evidence that TTD status changed. However, where there is no evidence claimant ever became aware of the changed status, a JCC must award TTD benefits. A contrary opinion after the fact is insufficient. Although the JCC specifically noted the letter was not in evidence, the DCA noted that letter was the only evidence that could have created a question of the claimant's credibility. As such, it was an abuse of discretion to deny TTD where the only admissible medical evidence indicated claimant was on TTD status.

Endnote:

1 *See Altman Contractors / North River Insurance Company v. Gibson,*___So.3d___(Fla 1st DCA 4/29/2011), where the claimant brought a claim for mold exposure. The dissent argued that as the medical testimony agreed that the claimant inhaled Aspergillus mold which caused her injuries. The dissent concluded that the majority decision, founded on the absence of contemporaneous air-quality studies as required by Section 440.02(1), has constructed a burden of proof for mold exposure claims which is artificial, illusory, and practically unachievable and represents a burden which far exceeds that imposed by the Legislature; see also *Staffmark / Avizent v. Merrell,* ___ So. 3d ___ (Fla. 1st DCA 8/12/2010) where Judge Webster's **concurring** opinion predicted that apportionment (and the prospect of injured workers being asked to pay the apportioned percentage of care from their own pockets) will "significantly increase litigation and, thereby both the economic and administrative burdens" upon the workers' compensation system. Judge Webster questioned whether "injured workers will be less likely to seek medical treatment" and wonders whether courts "might well conclude that because the right to benefits has become largely illusory, Florida's Workers' Compensation Law is no longer a reasonable alternative to common-law remedies and that ¼ workers have been denied meaningful access to courts."

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The Florida Bar 2012 Workers' Compensation Forum

April 12th – 13th, 2012

Agenda

WEDNESDAY, APRIL 11TH

6:00 - 8:00 p.m. Exhibitor Setup and Welcome

Welcome Reception from 7:00 - 8:00 p.m. for Early Arrivals
(Courtesy: Sponsoring Law Firms)

THURSDAY, APRIL 12th - National Ballroom A

TRACK 1:

8:30 – 8:45 a.m. Welcome by Florida Bar WC Section
Allison Hunnicutt Hauser, Forum Chair

8:45 – 9:45 a.m. Compensability of Accidents
Christopher Smith, Attorney, Tampa

9:45 – 10:45 a.m. The Employment Relationship; Employee Leasing Companies; Covered and Excluded Employment; Defenses to Claims; Fraud
Alan Kalinoski, Attorney, Orlando

10:45 – 11:15 a.m. Break

11:15 – 12:15 p.m. Major Contributing Cause and Other Hot Topics
Laurie Thrower Miles, Attorney, Lakeland

12:15 – 1:30 p.m. Lunch & Section Announcements
Jeffrey I. Jacobs, Section Chair

1:30 – 2:30 p.m. Repetitive Trauma, Exposure and Occupational Disease
Keith Pallo, Attorney, Palm Beach Gardens

2:30 – 3:30 p.m. Indemnity (Other than PTD) and Average Weekly Wage
Mark Touby, Attorney, Coral Gables
Joanne Prescott, Attorney, Orlando

3:30 – 4:00 p.m. Break

4:00 – 5:00 p.m. Employer's Liability/Immunity; Aguilera and Bad Faith
William H. Rogner, Attorney, Orlando

5:00 – 7:00 p.m. RECEPTION *(Courtesy: Sponsoring Law Firms)*

THURSDAY, APRIL 12th - National Ballroom C

TRACK 2:

8:30 – 8:45 a.m. Welcome by WCCP
Stacy L. Hosman, CWC, Chair, WCCP

8:45 – 9:45 a.m. Addiction - Florida Legislative Update
Mark Gerber, M.D., Orlando

9:45 – 10:45 a.m. Government Employees & Presumptions
Thomas P. Vecchio, Attorney, Lakeland
Kellie Biferie Hastings, Attorney, Maitland

10:45 – 11:15 a.m. Break

11:15 – 12:15 p.m. Examination of Medical Experts, Major Contributing Cause and Staffmark v. Merrell
Christopher Petrucelli, Attorney, Tampa
Glen Wieland, Attorney, Orlando

12:15 – 1:30 p.m. Sponsor Announcements
Stacy L. Hosman, Chair, WCCP

1:30 – 2:30 p.m. PEO Issues and Answers
Panel: Moderator, Dawn Traverso, Attorney, Aventura with representatives of Employment Leasing Companies

2:30 – 3:30 p.m. A View from the Bench
Panel: Moderator, Richard S. Thompson, with Thomas G. Portuallo, Judge of Compensation Claims, Daytona Beach, Gerardo Castiello, Judge of Compensation Claims, Miami, and Marjorie Renee Hill, Judge of Compensation Claims, Gainesville

3:30 – 4:00 p.m. Break

4:00 – 5:00 p.m. Trial Practice and Use of Vocational Experts
Panel: Moderator, Bill England, with Robert J. Grace, Jr., Michael J. Winer, Gil Spruance, and David Patten

5:00 – 7:00 p.m. Reception *(Courtesy: Sponsoring Law Firms)*

FRIDAY, APRIL 13th - National Ballroom A

TRACK 1:

8:30 – 8:45 a.m. Introductory Comments

8:45 – 9:45 a.m. Medical Benefits, Managed Care and Rehabilitation Benefits
George Kagan, Attorney, West Palm Beach

9:45 – 10:45 a.m. Social Security and Other Offsets, and Supplemental Benefits
James F. Fee, Jr., Attorney, Miami

10:45 – 11:15 a.m. Break

11:15 – 12:15 p.m. Controversies between Carriers and W/C Liens
Thomas A. Moore, Attorney, Orlando

12:15 – 1:30 p.m. Lunch

1:30 – 2:30 p.m. Trial Practice and Procedure
Henry H. Harnage, Judge of Compensation Claims, Miami
Steven P. Kronenberg, Attorney, Ft. Lauderdale

2:30 – 3:30 p.m. Attorney's Fees & Costs
Michael J. Winer, Attorney, Tampa

3:30 – 3:45 p.m. Break

3:45 – 4:45 p.m. Permanent Total Disability
James H. Smith, Attorney, Tampa

4:45 p.m. Adjournment

FRIDAY, APRIL 13th - National Ballroom C

TRACK 2:

8:30 – 8:45 a.m. Introductory Comments

8:45 – 9:45 a.m. Managing and Achieving the Complicated Workers' Compensation Settlement
Jason Lazarus, Attorney, Orlando

9:45 – 10:45 p.m. Death and Dependency
Theo Johns, Attorney, Jacksonville

10:45 – 11:15 a.m. Break

11:15 – 12:15 p.m. Employment Law Causes of Action that Flow from Workplace Injuries
Allison H. Hauser, Attorney, Jacksonville
Edward L. Birk, Attorney, Jacksonville

12:15 – 1:30 p.m. Lunch

1:30 - 2:30 p.m. Probate, Guardianship and Workers' Compensation
Alex Cuello, Attorney, Miami

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REGISTRATION FEE *(CIRCLE ONE):*

Florida Bar W/C Section Members: **$395.00** ● Non-section member: **$470.00** ● Legal Assistants: **$159.00** ● ***State*** Mediators: **$95.00** ● *Other (see below): **$N/C**

*Full time law college faculty, full time law students, or persons attending under the policy of fee waivers (e.g. *Supreme Court, DCA, Circuit and County Judges, Magistrates, Judges of Compensation Claims, Administrative Law Judges, and full-time legal aid attorneys if directly related to client practice):* $-0- (i.e. No Charge)

Late Registrations (after March 30th, 2012) and On-Site Registrations: **Add $40.00** *Please register early!*

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The Florida Bar Continuing Legal Education Committee and
The Workers Compensation Section present

Questions to Ask Your IME Provider: What You Want to Know vs. What You Need to Know

COURSE CLASSIFICATION: INTERMEDIATE LEVEL

Recorded, October 11, 2011

Course No. 1293R

AUDIO CD ORDER FORM

This seminar provides the attorney with an understanding of the questions they should ask their IME provider. The IME should address diagnosis, causality, appropriate treatment, MMI status, impairment rating, and abilities and limitations for return to work. It is helpful to the IME provider when the referral source drafts well constructed questions. Asking the poorly constructed questions can create problems for both the IME provider and the referral source. Dr. Jeffrey Penner has more than 30 years experience as an Orthopaedic Surgeon and providing medical legal opinions. He addresses the manner in which a referral source should ask the IME providers to opine on a case being seen for an IME.

Welcome and Introductions
Dawn Traverso, Aventura

Questions to Ask Your IME Provider: What you Want to Know versus What you Need to Know
Jeffrey S. Penner, MD

Program:

- How to ask questions to get a substantiated opinion regarding diagnosis: Diagnosis should be based on evidenced-based medicine to support the diagnosis, and consideration and/or rule-outs of diagnoses that may have been considered by other examiners and treating physicians in the review of records
- How can you ask Causality Questions to address the most problematic cases: The Rules of Causality will be presented, and discussion of the problematic causality cases; that of acute injury overlaid on degenerative changes.
- How to address Best Practices Care and the associated costs of care: Best Practices treatment will be discussed and the link to treatment for causally related conditions versus pre-existing conditions.
- How to ask the question to get a properly constructed Impairment Rating: Using the FL or AMA Guides takes experience and diligence. Discussion of the common errors will be presented and how you can ask for an evidence based Impairment Rating
- How to ask questions regarding Work Abilities and Limitations to get evidenced based opinions: A discussion of the scope of approaches a physician may take to address these issues, including a Functional Capacity Evaluation (FCE) versus a Functional Medicine Evaluation.

Question and Answers

Closing Remarks

CLE CREDITS

CLER PROGRAM	CERTIFICATION PROGRAM
(Max. Credit: 1.5 hours)	(Max. Credit: 1.0 hour)
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TO ORDER AUDIO CD COURSE MATERIALS BY MAIL, SEND THIS FORM TO The Florida Bar, Order Entry Department: 651 E. Jefferson Street, Tallahassee, FL 32399-2300 with a check in the appropriate amount payable to The Florida Bar **or credit card information filled in below**. If you have questions, call 850/561-5831.

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AJC: Course No. 1203C

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The Florida Bar – Workers' Compensation Section Application for Membership

The practice of Workers' Compensation Law is constantly changing, and the Workers' Compensation Section of The Florida Bar seeks to keep its members abreast of all the recent developments in the area through communication. Membership in the section provides access to the section's newsletter *The News & 440 Report*, the section web page at: www.flworkerscomp.org, sponsored continuing legal education programs and section meetings.

Membership in this Section will:

- Provide an organization for those with an interest in workers' compensation law.
- Provide a forum for communication and education for the improvement and development of the practice area of workers' compensation law.
- Provide a forum for the education of the Bar about the legal needs of the work force and for the education of the public on their legal rights and the availability of legal services.
- Entitle the member to a reduced fee for section sponsored continuing legal education programs.
- Support the pursuit of Legislation important to workers' compensation law attorneys and their clients

To join, mail this completed application with your check to:

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651 E. JEFFERSON STREET
TALLAHASSEE FL 32399-2300

Enclosed is my check made payable to The Florida Bar for the appropriate amount (check one):

___ **Member of the Section (active member of The Florida Bar): $50**

___ **Affiliate member of the Section (Full-time, Florida law school student): $30**

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(Note: The Florida Bar dues structure does not provide for prorated dues. Membership expires June 30.)

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