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Florida State Capitol buildings

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Section Calendar

2018

APRIL 12 – 13, 2018
Florida Bar Workers' Compensation Forum
The Omni Orlando Resort at ChampionsGate
1500 Masters Blvd
Championsgate, FL 33896

JUNE 28 – 30, 2018
Long Range Planning Meeting & Retreat
Omni Grove Park
Asheville, NC

For more details, visit www.flworkerscomp.org.

Message from the Chair

Your editor for this addition of the News & 440 Report, asked me if I would be willing to prepare an article for the issue. I readily agreed as past issues suggested the chair is obligated to present some statement to the section membership. When I asked what exactly he wanted, he provided sage guidance by telling me to write about whatever I wanted to write about. No pressure there.

Paul M. Anderson
Chair

My first thought was to reminisce on my thirty years as a workers' compensation practitioner. I could tell the story of the JCC who suffered from intestinal problems dating back to his military service. As a consequence, the judge would occasionally experience stomach discomfort. To let those in the room know it was him (if you get my drift), he would strike a match under the table. One day, the judge was hearing a claim with defense counsel from out of the area. When the judge struck a match, the attorney spoke up convinced there must be a fire and urging the judge to have everyone exit the room.

Then there was the final hearing where my client was carrying a gym bag for no apparent reason. This was in the days before security. I knew the JCC and defense counsel (who later became a JCC) were packing. My fear was my client was packing too, leaving me as the only one in the room not armed. I asked to look into his backpack during a break. Turned out he was packing, though it was a hydraulic jack. I still don't understand why my client felt the need to carry a hydraulic jack into his compensation hearing.

Then there was the one where, oops. I'd better stop telling stories for fear of offending a sitting JCC or a practitioner. Maybe I should address a serious subject. How about we talk about the state of Office of the Judges of Compensation Claims.

Prior to 1992, JCC salaries were tied to what circuit court judges were paid. JCC's could count on the periodic pay raise. For reasons no one who was there at the time can recall, the tie in was removed from the statute. Our JCC's have not received proper raises since. At one time, our JCC's were assured of reappointment if the JNC recommended they be reappointed. The late Governor Lawton Chiles challenged that process so as to completely control appointments. Mark it as a success for a sitting Governor who relishes controlling appointments. Mark it a failure for the workers' compensation system. We now see JCC's serving the minimum four year term and being denied reappointment. We also have long sitting JCC's who are favorably viewed by both sides being denied reappointment.

Underpaid and with little job security, is it any wonder the Workers' Compensation JNC is having a dickens of a time attracting applicants for vacant JCC seats. Not to disparage the actual applicants, but only four practitioners applied for the vacancy in Gainesville. One, yes, one practitioner applied in response to the initial publication for the opening Tallahassee seat. Why would a skilled, experienced practitioner give up a successful private practice for a job that probably pays less than he or she currently earns. A job that offers no job security to the attorney who is sacrificing his or her practice.

Bottom line. The business community, the insurance industry, the claimant's bar, the Florida Legislature and the Governor need to set aside whatever objections they may have to specific JCC's or to JCC rulings. We have to have a salary structure and terms in office that attract highly qualified applicants in adequate numbers to assure that the state workers' compensation system addresses the rights and responsibilities of the parties in an intelligent, efficient way. The stakeholders in the system have no one to blame but themselves if we don't address this issue. To this end, the Section has offered to assist the JCC's in amending Chapter 440 to reestablish a tie-in for JCC salaries. We have prepared legislation, secured sponsors and, as I write this article, have seen the bill pass through its first committee reference in the Florida Senate. I hope that by the time you read this article, we will have restored our Judges compensation to a level commensurate with their judicial service to the people of Florida.

A Brief Word From the Guest Editor

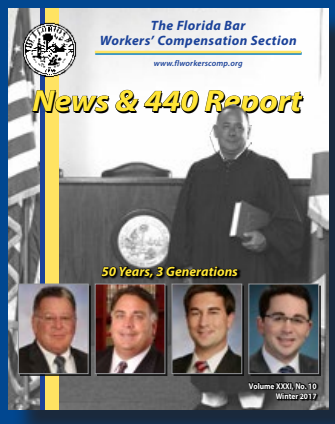
By Richard S. Thompson

Upon my return from the Executive Council's May treat in Charleston, South Carolina, my legal team was thrilled to hear that I had volunteered them to write this edition of the 440 News and Report. So with unbridled enthusiasm, they have collectively chosen relevant and timely topics of interest for workers' compensation practitioners, both for the injured workers and employer/carriers alike.

First, a little background on Zenith's Florida Staff Counsel legal team. We are comprised of 10 full-time attorneys exclusively practicing Florida workers' compensation law, and one Bill Review attorney. We are housed in three offices, Orlando, Sarasota and Hollywood. We work directly with our claims team, both prior to and during litigation. We also manage our limited use of outside counsel due to conflict or venue issues. Although all of our attorneys exclusively represent our company and our policyholders, many of us have practiced on the "other side" representing injured workers in the past. My charge to the team in this instance was to write an unbiased, balanced and current analysis of the current state of the law in areas which both sides of the bar grapple with on a daily basis.

To lead off, Shari Hall and Mark Glaser tackle the current state of the law as it applies to utilizing the one-time change in treating physician, otherwise known as the OTC (because in our world, everything has to have an acronym!). Next, Marissa Hoffman, Robin Ross and Kathy Wilson address the thorny issue of the misrepresentation defense. Brendan McGettigan then provides a very complete and thoughtful analysis of the current state of the law with respect to the major contributing cause defense. Finally, Carol Brodie, a member of the California Bar and a registered nurse with extensive experience, provides a detailed analysis of the current state of our medical provider reimbursement system. Although attorneys on both sides, as well as the judges of compensation claims, love nothing better than to say that billing disputes lie within the province of the Office of Medical Services, referred to as "OMS" (yes, another acronym!), it is important for all practitioners to understand the basics of the reimbursement process as it has a significant impact upon our industry as a whole and is probably worth the Legislature's attention. I hope you enjoy this edition of the 440 News and Report as much as I enjoyed assigning this project to my team!

Richard S. Thompson is the Vice President of Claims-Legal for Zenith Insurance Company. He is responsible for defense of all claims outside of the state of California. He is Board Certified by The Florida Bar as a specialist in workers' compensation law, is AV Rated by Martindale-Hubbell, and has practiced workers' compensation law statewide for 29 years, including over nine years of service as a Judge of Compensation Claims in Orlando. Mr. Thompson is a Fellow in the College of Workers' Compensation Lawyers, Member of the Executive Council of the Florida Bar Workers' Compensation Section, is Past Chair of the Workers' Compensation Section of the Florida Bar, served as President of the Florida Conference of Judges of Compensation Claims, and has testified before the Florida Legislature regarding workers' compensation issues. He is a member for the Florida Workers' Compensation Hall of Fame.



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Navigating the Uncertain Waters of Hospital and Provider Reimbursement in Florida.

By Carol Brodie

The purpose of this article is to educate the reader about how medical providers are reimbursed under the Florida Workers' Compensation statute. Most practitioners and Judges of Compensation Claims avoid the subject by agreeing that the Judges do not have jurisdiction over billing disputes, pushing the issue off on the Office of Medical Services as dictated by statute. But it is important for all workers' compensation practitioners to have a basic understanding of where the medical money goes.

Indemnity payments used to be the highest expenditure on a claim. Over the past few decades, the driver of claim cost has flipped from indemnity payments to medical spend. Attorneys may be unaware how bills are paid or what, if any, options there are to contain medical costs. This article hopes to demystify medical bill reimbursement in Florida.

Historical perspective

The workers' compensation system was created as a self-executing, no fault system to remove work place injuries from the civil courts and has become the exclusive remedy for injured workers. Florida entered the work comp arena later than many states with the first law, HB 29, becoming effective July 1, 1935. This new law provided for the creation of the Florida Industrial Commission consisting of three members, now known as the Three Member Panel. The first work comp medical fee schedule was adopted in 1938 to establish consistent reimbursement for medical services. In 2001, the Agency for Health Care Administration ("AHCA") was elevated to department status and received the Medical Services portion of the Division of Workers' Compensation ("DWC").

The DWC's mission statement is "To actively ensure the self-execution of the workers' compensation system by educating system participants of their rights and responsibilities; by leveraging date to deliver exception value; and by holding participants accountable for fulfilling their obligations."

Today's environment

Under Florida Statute 440.13(12) the Department of Financial Services ("DFS") delegates rule making authority to the Three Member Panel to establish maximum medical reimbursement schedules, sometimes referred to as fee schedules. Those schedules are found within Rule 69L-7 and organized by provider type in three reimbursement manuals: Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2016 Edition, Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2015 Edition, Florida Workers' Compensation Reimbursement Manual for Hospitals, 2014 Edition.

The maximum medical reimbursement schedule, or fee schedule, is often based on a maximum reimbursement amount, or MRA. The values given the MRAs are based on reimbursement data obtained by DFS and is provider type and location specific. When there is a MRA value, the reimbursement is simple. The carrier reimburses the provider or facility that value. However, there are many billing codes and not all have an MRA. In the absence of an MRA, the carrier must determine the reasonable value for that service. Therein lays the controversy.

Provider Reimbursement:

When a billing code from a Health Care Provider (non-facility) does not have an MRA, the carrier must either negotiate with the provider or pay a "reasonable" value. Fortunately, most of the codes billed by providers have MRAs.

Ambulatory Surgery Center Reimbursement:

When a billing code from an Ambulatory Surgery Center does not have an MRA, the bill is reimbursed at 60% of the billed charge. The majority of the time this methodology works well. However, as discussed below, there are times that this methodology conflicts with the goals of the workers' compensation system.

Hospital Reimbursement:

Inpatient and outpatient hospital reimbursement is a bit more complicated. Between 2009-2014 hospital charges were high; in 2015 a revision to the fee schedule provided an MRA for some billing codes. However, many services are not reflected in the codes carrying an MRA.

For outpatient services, there are some services with an MRA but generally non-scheduled visits are reimbursed at 75% of billed charges; scheduled visits are reimbursed at 60% of billed charges. Inpatient admissions are paid on a per diem basis ($2,283.40-3.850.33 per day depending on the services and type of facility) unless the total billed charges meet the set dollar amount of $59,891.34, less the charges for surgical implants, which is referred to as the "stop loss." If the total billed charges meets or exceeds the stop loss, the bill is paid at 75% of the billed charges.

On its face, this seems to be a reasonable reimbursement methodology and the result is reasonable in many cases. However, one reason to have a fee schedule is to

• *Uncertain Waters – continued*

provide certainty in reimbursement. A percent of billed charge methodology makes certainty difficult. For example, each facility may have a different opinion as to what constitutes a "reasonable" charge. Even worse, without a definition of "reasonable, the system is subject to abuse in that the provider may charge whatever they want as long as they deem it to be reasonable.

A dramatic, yet very real example is imaging charges. According to the fee schedule, a scheduled outpatient CT scan reimburses approximately $300-600. That same CT scan performed as an unscheduled outpatient (i.e., in an ER) reimburses at 75% of billed charges. The same service using the same hospital resources (CT scanner, radiology staff) is now reimbursed at a rate of five (5) to twenty five (25) times higher. Billed charges for CT scans have risen dramatically over the past few years with charges, with our company seeing as high as $12,000-16,500 for a single CT scan. This is clearly not the intended reimbursement result of the fee schedule but under the current structure it is difficult to manage.

Another reason to have a fee schedule is to provide equity in the marketplace. The current methodology does not provide equity in the marketplace as hospitals receive different reimbursement for the same service. For example, Hospital A may bill $1,000 for a service. Hospital B in the same community may bill $5,000 for the same service. A percent of billed charge affords Hospital B a windfall solely due to the amount they billed. A set fee schedule based on the cost incurred to deliver a service plus an acceptable profit margin is the only way to truly provide equity in the marketplace.

While the inpatient hospital fee schedule provides for a per diem reimbursement, often hospitals billed charges are rising to the level over stop loss. This then gets reimbursed at 75% of billed charge creating the same challenges as described above.

Current state of the law – legislative intent

With hospitals being entitled to 60-75% of billed charges, regardless of whether the billed charges are in line with amounts billed by comparable providers in the state, the current reimbursement methodology can lead to absurd results.

For example, what would prohibit hospitals from charging $1 million for a CT scan and thereafter demanding that they be paid $750,000 since that represents 75% of their billed charges? Accepting this position would mean that workers' compensation carriers would have to pay three quarters of a million dollars for the CT scan -- the same CT scan that hospitals charges $500-1,500 for non-workers' compensation cases.

Fortunately, one can argue that the law of this state does not allow price gouging. In fact, it is the intent of the Florida State Legislature that a provider's billed charges must be reasonable to begin with. The expressed legislative intent of Florida's Workers' Compensation laws is found in Section 440.015.

> "[i]t is the intent of the Legislature that the Workers' Compensation Law be interpreted so as to assure the quick and efficient delivery of disability and medical benefits to an injured worker and to facilitate the worker's return to gainful reemployment *at a reasonable cost to the employer.*" (Emphasis added.) That same overall intent statute makes clear that it is the duty of the regulatory oversight bodies to make sure that provider payments are cost effective. Specifically, Section 440.015 states that "[t]he department, agency, the Office of Insurance Regulation, and the Division of Administrative Hearings *shall administer the Workers' Compensation Law in a manner which facilitates the . . . cost-effective delivery of payments*. (Emphasis added.)

Other provisions of the law support the position that the charges levied by hospitals and other providers must initially be "reasonable" in order to satisfy the underlying legislative intent of the Workers' Compensation regulatory scheme. For example, Section 440.13 of the Florida Statutes governs the provision of medical services to injured workers, and expressly highlights the importance of reasonableness in adopting reimbursement schedules for service providers. Subsection (12)(d) of the statute creates a three-member panel for determining maximum reimbursement allowances and specifies guidelines which must be followed in assessing reimbursement allowances. The statute explains that "[r]eimbursement for all fees and other charges must not exceed the amounts provided by the uniform schedule of maximum reimbursement allowances as determined by the panel…" The statute goes on to recognize the importance of looking at market data for the panel's determination of reimbursement allowances. Specifically, Subsection 440.13(12)(d) provides that the panel must first develop a reasonable set of price data which is "representative of prevailing charges in the state for similar treatment . . ." The statute mandates that "[i]n establishing the uniform schedule of maximum reimbursement allowances, the panel must consider: (1) the levels of reimbursement for similar treatment . . . ;[and] (2) the impact upon cost to employers for providing a level of reimbursement . . . ." Finally, Subsection 440.13(12)(d)(3) concludes that "[t]he uniform schedule of maximum reimbursement allowances *must be reasonable*, [and] must promote health care cost containment and efficiency . . . ." (Emphasis added.)

Given the unequivocal language in the legislative intent statutes necessitating an examination of the reasonableness in setting reimbursement levels, we cannot simply ignore whether billed charges are reasonable when compared to other comparable providers.

• *Uncertain Waters – continued*

Florida Statutes, Section 440(44)(2) provides "the intent of the Legislature that the department, the agency, and the Division of Administrative Hearings assume an active and forceful role in its administration of [the Worker's Compensation Act], so as to ensure that the system operates efficiently and with maximum benefit to both employers and employees." The appellate courts consistently reject any interpretation of the law that is not consistent with this intent. See, e.g., Moore v. Servicemaster Commercial Services, 19 So.3d 1147, 1151 (Fla. 1st DCA 2009) (rejecting statutory interpretation that conflicts with legislative intent that the cost of benefits be **provided at a reasonable cost to the employer**. See also, Colomar v. Mercy Hospital, Inc., 461 F. Supp.2d 1265 (S.D.Fla. 2006) (Florida law requires the amount of an open pricing contract to be reasonable), citing, Payne v. Humana Hospital Orange Park, 661 So.2d 1239, 1241 (Fla. 1st DCA 1995) and Mercy Hosp. v. Carr, 297 So.2d 598, 599 (Fla. 3rd DCA 1974). In Colomar, the court determined that several factors are relevant in the analysis of whether hospital charges are reasonable, including but not limited to the hospital's internal cost structure, the rates charges, the payment amounts actually received for these services, and what other hospitals in the relevant market charge for similar services.

Florida Statutes, Section 440(44)(2) and the case law cited above make it clear the carrier, if not the Department, must be allowed to analyze and, if appropriate, challenge the reasonableness of all medical bills in a reimbursement dispute under Section 440.13(7).

The DFS has the authority and responsibility to audit, investigate and resolve disputes relating to unfair or unreasonable charges and price-gouging under section 440.13(11), Fla. Stat. *See, e.g.* Carswell v Broderick Construction, 583 So.2d 803, 804 (Fla. 1st DCA 1991). Section 440.13(11)(a), Fla. Stat. provides, in relevant part, as follows:

> "*The department may investigate* health care providers to determine whether providers are complying with this chapter and with rules adopted by the department, whether the providers are engaging in overutilization, *whether providers are engaging in improper billing practices*, and whether providers are adhering to practice parameters and protocols established in accordance with this chapter. *If the department finds that a health care provider has improperly billed*, overutilized, or failed to comply with the department rules of the requirements of this chapter, including, but not limited to, practice parameters and protocols established in accordance with this chapter, *it must notify the provider of its findings and may determine that the health care provider may not receive payment from the carrier* or may impose penalties as set forth in subsection (8) or other sections of this chapter." (Emphasis added.)

Conclusion

It is safe to say that hospitals, employers and carriers all want profitable and successful businesses and Florida's economy to thrive. We also all want Florida's hospitals to provide state of the art care to injured workers and insurance carriers to provide quality coverage for injured workers. However, with medical costs continuing to rise, providers and carriers need to work with the Department of Financial services to develop cost containment strategies that are equitable to all parties. While the use of the reimbursement dispute process is one way to resolve billing disputes, it is time consuming is not the most efficient. A set fee schedule based on the cost incurred to deliver a service plus an acceptable profit margin may be the only way to truly provide certainty in reimbursement and equity in the marketplace.

Carol Brodie received her law degree from Concord University School of Law, was invited into the Concord University Honors Society and admitted to the California Bar in 2004. She received a Master's Degree in Nursing Administration from the University of Texas Health Sciences Center and her undergraduate degree in Nursing from Virginia Commonwealth University/Medical College of Virginia.

As a Nurse Attorney, Carol has a unique background in a variety of clinical settings, healthcare, management and the law. She previously was employed with Anthem, Inc, one of the nation's leading health benefits company. Carol is currently employed with Zenith Insurance as a Bill Review Attorney where she has oversight responsibility of the evaluation and negotiation of complex bills and the medical bill reimbursement dispute resolution process.

The Misrepresentation Defense: Where Does it Stand Now?

By Marissa Hoffman, Robin Ross, and Katherine L. Wilson

Of all the many provisions found in Chapter 440, none evoke as much debate or challenge as the misrepresentation section. Prior to 1998, §440.09(4), F.S. outlined that Judges of Compensation Claims were not administrative hearing officers, a court or a jury and therefore, did not have jurisdiction to make a §440.105 determination. *See E.H. v. Temporary Labor Source, Inc.,* 687 So.2d 884 (Fla. 1st DCA 1997). However, in 1998, the Legislature amended §440.09(4), F.S. to specifically allow Judges of Compensation Claims to make misrepresentation determinations. In other words, the statute now provided the jurisdiction to the Judges of Compensation Claims to decide issues of misrepresentation in workers compensation cases. The statute specifically noted that it applied to all accidents, regardless of the date of accident. Therefore, the amendment is procedural. *Russell v. Jacobs,* 782 So2d 404 (Fla. 1st DCA 2001).

Since that time, this portion of the statute has become the source of extensive litigation and contention. While this provision of the statute can be asserted against claimants and employer/carrier's equally, the reality is that it is most often used by the defense in an effort close a claim conclusively.

Specifically, §440.105(4)(b), F.S., deems it unlawful to knowingly make, or cause to be made, any false, fraudulent, or misleading oral or written statement for the purpose of *obtaining or denying* any benefit or payment. While §440.105 (7), F.S., outlines that anyone who knowingly and with intent to injure, defraud or deceive by filing a statement of claim with the false or misleading information commits, insurance fraud punishable as provided in §817.234, the most tangible sanction for violating §440.105(4), F.S, is found at §440.09(4)(a), which states, that "an employee" shall not be entitled to compensation or benefits under this chapter if any Judge of Compensation Claims...determines that the employee has knowingly or intentionally engaged in any of the acts described in §440.105... The constitutionality of §440.105(4), F.S. has been upheld. *Medina v. Gulf Coast Linen Services,* 825 So. 2d 1018 (Fla. 1st DCA 2002).

Thus, the misrepresentation section of the statute only empowers the Judge of Compensation Claims ("JCC") to sanction claimants. The process by which an attorney or carrier may be sanctioned for violating §440.105, F.S., is set forth in §440.106(1) & (3), F.S., which provides as follows: 1) Whenever any circuit or special grievance committee acting under the jurisdiction of the Florida Supreme Court finds probable cause to believe that an attorney has violated §440.105, such committee may forward to the appropriate state attorney a copy of the findings of probable cause and a copy of the report being filed in this matter; 3) Whenever any group or individual self-insurer, carrier, rating bureau, or agent or other representative of any carrier or rating bureau is determined to have violated §440.105, the agency responsible for licensure or certification may revoke or suspend the authority or certification of the group or individual self-insurer, carrier, agent, or broker. In other words, the misrepresentation portion of the statute does not grant the JCC any authority to determine whether an attorney or carrier has violated §440.105, nor does it give the JCC any authority to impose sanctions for such violations. *McArthur v. Mental Health Care, Inc.,* 35 So.3d 105 (Fla. 1st DCA 2010).

With this recognition is the significant caveat that a JCC lacks jurisdiction to rule on an employer/carrier's misrepresentation defense in the absence of a pending petition for benefits having been filed by the claimant. *Polston v. Hurricane Island, Outward Bound*, 920 So.2d 766 (Fla. 1st DCA 2006). If there is no pending petition for benefits, then the JCC lacks jurisdiction to decide misrepresentation. *Fla. Dept. of Transportation v.* Rippy, 67 So.2d 3d 1122 (Fla. 1st DCA 2011). In other words, the employer/carrier cannot file a motion or other pleading in an effort to invoke the jurisdiction of the JCC claims to address any misrepresentation allegations as the statute only permits employees to file pleadings invoking the jurisdiction of the JCC. *Id.* Without a pending petition for benefits, the JCC has no jurisdiction to consider the misrepresentation defense. *Id.* Likewise, the parties cannot stipulate to jurisdiction over the subject matter where none exists. *Id.*

Misrepresentation is a question of fact to be determined by the JCC. *Pinnacle Benefits v. Alby,* 913 So. 2d 756 (Fla. 1st DCA 2005). A determination of misrepresentation requires a two part inquiry. The JCC must determine whether a false, fraudulent, or misleading statement was made by the claimant *and* whether the statement was made with the intent to obtain benefits. *City of Hialeah v. Bono,* 207 So. 3d 1030 (Fla. 1st DCA 2017). The burden of proof is on the employer/carrier by a preponderance of the evidence. *Singletary v. Yoder's*, 871 So. 2d 279 (Fla. 1st DCA 2004) and *Village of North Palm Beach v. McKale*, 911 So. 2d 1282 (Fla. 1st DCA 2005).

Notwithstanding, an employer/carrier does not have

• *Misrepresentation Defense – continued*

to wait for a judicial determination of a knowing and intentional misrepresentation or misstatement in order to terminate workers' compensation benefits. *Alvarez v. Unicco*, 958 So. 2d. 951 (Fla. 1st DCA 2007). Rather, the employer/carrier may unilaterally terminate benefits. *Id.* However, the issue of whether a misrepresentation made after the entitlement to benefits is legally established will disqualify an offending claimant from the right to the payment of those benefits has not yet been decided. *Leggett v. Barnett Marine, Inc.,* 167 So.3d 480 (Fla. 1st DCA 2015). Likewise, if the claimant overcomes the defense, then the employer/carrier could be exposed to liability for benefits and attorney's fees. *Carrillo v. Case Engineering*, 53 So.3d 1214 (Fla. 1st DCA 2011). In fact, employer/carrier paid attorney's fees may be due if the claimant successfully prevails over the misrepresentation defense, even if benefits sought by the claimant are denied. *Id.*

So what constitutes misrepresentation? While some examples are clear, others are not so.

The issue is whether the claimant knowingly or intentionally made any false, fraudulent, incomplete, or misleading statement, whether oral or written, for the purpose of obtaining workers compensation benefits or in support of the claim for benefits. *Village Apartments v. Hernandez*, 856 So. 2d 1140 (Fla. 1st DCA 2003). For example, misrepresentation can be found where the claimant testifies in deposition that he had no prior motor vehicle accidents when he actually had three prior motor vehicle accidents. *Id.* Or, where the claimant gives false, incomplete or misleading statements regarding his medical history during his deposition which the JCC finds was intentionally or knowingly made for the purpose of obtaining workers compensation benefits. *Smith v. Employee Leasing Solutions*, 57 So.3d 853 (Fla. 1st DCA 2011).

It is not necessary that the false, fraudulent, or misleading statement be material to the claim. *Village of N. Palm Beach v. McKale*, 911 So.2d 1282 (Fla. 1st DCA 2005). The misrepresentation must only be made for the purpose of obtaining workers compensation benefits. *Id.*

In other words, in order to prove misrepresentation, the employer/carrier is not required to link the allegedly false statements directly to the particular injury and benefits being sought. *THG Rentals & Sales of Clearwater v. Arnold*, 196 So.3d 484 (Fla. 1st DCA 2016). In this case, the claimant suffered compensable injuries to his back and right knee. *Id.* at 486. The claimant filed multiple petitions for benefits seeking medical and indemnity benefits with respect to both injuries. *Id.* By the time of the hearing, the claimant only sought benefits for his right knee injury. *Id.* The employer/carrier denied benefits based upon misrepresentation and presented surveillance video, evidence of earnings, and testimony of doctors who treated the claimant's back to demonstrate that the claimant had not been truthful with his doctors. *Id.* at 487. The JCC rejected the misrepresentation defense because the alleged misrepresentation did not relate to the claimant's right knee, but only his back injury. *Id.* The appellate court reversed on the basis that if the claimant made any misrepresentation for the purpose of obtaining benefits, then the claimant is barred from entitlement to benefits, even if the misrepresentation is unrelated to the injury or benefits based on that injury. *Id. See also Citrus Pest Control v. Brown*, 913 So. 2d 754 (Fla. 1st DCA 2005) (holding that once there was a finding that the claimant intended to mislead by making false or misleading statements that were designed to advance his claims, he was precluded from receiving any and all workers' compensation benefits, regardless of the medical evidence).

Yet, the statements must be made to obtain workers' compensation benefits in the claim at issue before the judge of compensation claims. *Paulson v. Dixie County Emergency Med Servc.,* 936 So.2d 1109 (Fla. 1st DCA 2006). To require coverage be forever barred simply because the employee had, at one time, committed one of the §440.105 prescribed acts would be unduly harsh. *Id.* at 1111. In *Paulson,* the claimant obtained benefits for three work-related accidents in three years. *Id.* at 1110. The employer/carrier provided benefits for the claims in the first two accidents and never defended either on the grounds that the claimant committed any of the acts prohibited in §440.105, F.S. *Id.* However, the employer/carrier denied the third accident occurred. *Id.* Following an evidentiary hearing, the JCC concluded that the claimant did suffer a third workplace accident which resulted in injury, but denied the claim on the basis that the claimant made false, fraudulent, incomplete or misleading statements as defined in §440.105(4)(b), F.S., to obtain workers' compensation benefits for the second workplace accident. *Id.* The appellate court found that although competent, substantial evidence supported the JCC's conclusion that the claimant committed one of the prohibited acts of §440.105(4)(b), F.S., in a different workers' compensation claim, the JCC erred in applying the exclusion of §440.09(4) to the instant claim. *Id.* Thus, §440.09(4), F.S. applies solely to a specific accident and does not apply to injuries not connected with the acts prescribed in §440.105, F.S.

In *Steel Dynamics v. New Millenium,* 46 So. 3d 641 (Fla. 1st DCA 2010), the claimant returned to work after the industrial accident in a modified duty position. About seven months later, the claimant resigned his position, citing economic reasons and that he was accepting a new job with another company. *Id.* He made no mention of having any difficulties performing his work as a result of his accident. *Id.* After a year at the new employment, the claimant was unable to continue doing the work as a result of the industrial accident, and the subsequent employer terminated him because they could not accommo-

• *Misrepresentation Defense – continued*

date his restrictions. *Id.* At the final hearing, the claimant testified that he left his employment with the employer because of the physical difficulties he was having, not because of the economic reasons cited in his resignation later. *Id.* The claimant testified that he provided those reasons for leaving because he wanted to protect his employment opportunities in the future. *Id.* The employer/carrier argued that the claimant made false statements in his resignation letter and that all benefits should be barred. *Id.* The court held that the claimant did not make a misrepresentation with a specific intent to deceive for the specific purpose of securing compensation benefits. *Id.* Therefore, there was no forfeiture of workers' compensation benefits. *See also Quiroz v. Health Cent. Hosp., 929 So. 2d 563* (Fla. 1st DCA 2006).

As outlined in §440.105(4)(b)1 and §440.105(4)(b)9, F.S., the court held that providing a false Social Security number after the industrial accident is sufficient to prove misrepresentation. *Arreola v. Administrative Concepts,* 17 So. 3d 792 (Fla. 1st DCA 2009). The claimant provided the false number when he was transported by ambulance to the hospital, at the pharmacy when obtaining medication, and at the telephone interview with the employer/ carrier's investigator. *Id.* At the final hearing, the claimant argued that he presented the number solely for identification and lacked the requisite intent to obtain benefits. *Id.* However, the judge of compensation claims found otherwise and determined that the claimant's intent was to secure benefits. *Id.*

The case of *Dieujuste v. J. Dodd Plumbing,* 3 So.3d 1275 (Fla. 1st DCA 2009), discusses the value of surveillance. The employer/ carrier obtained surveillance video showing the claimant walking short distances and helping his wife with laundry. *Id.* Later that day, the surveillance showed the claimant being handed a cane as he walked into the doctor's office. *Id.* In his report, the doctor reported that the claimant complained of severe pain and was reluctant to weight bear on the left lower extremity. *Id.* The claimant's other doctors testified that the claimant's activities on the surveillance were not inconsistent with his statements or presentation. *Id.* The court held that there was no misrepresentation because the claimant's presentation was nonverbal and the statute requires an oral or written statement. *Id.* The court explained that surveillance has value only to the extent it contradicts or disproves an oral or written statement made by the claimant. *Id.*

In contrast, in *Lucas v. ADT,* 72 So. 3d 270 (Fla. 1st DCA 2011), the court held that the doctor's extensive testimony was evidence of the claimant's nonverbal conduct which was inconsistent with her reports of pain, which was sufficient to support the finding of misrepresentation. The claimant had told the doctor that her pain was 4/10 and had written that it was 5/10. *Id.* The doctor testified that the claimant's pain behavior was inconsistent with these statements and was exaggerated. *Id.* He noted that the claimant walked in the exam room, but then needed help ambulating to the x-ray room because of her severe pain. *Id.* The doctor described the claimant as theatrical in the exam room. *Id.* She cried when he asked her to walk and did a visual exam of her back. *Id.* Also, at the time of the exam, the claimant had been sitting with her legs dangling and had no signs of pain during the interview. *Id.* Yet, when the doctor examined her physically, her pain complaints were inconsistent with her actions. *Id.* The court held that the claimant's behavior gave rise to misrepresentation. *Id.*

Finally, misrepresentation must be asserted timely and with specificity in the pretrial stipulation. *Isaac v. Green Iguana, Inc.,* 871 So.2d 1004 (Fla. 1st DCA 2004). Likewise, the application of the statute must be supported by relevant evidence.

CONCLUSION

The misrepresentation portion of the statute is and will continue to be a source for litigation and challenge. These cases demonstrate the complexity of §440.105(4)(b) and case specific application. Firstly, the judge of compensation claims must determine whether a claimant's oral or written statement was false, fraudulent, incomplete, or misleading. This is a very fact specific issue. Then, if the JCC determines that it was, the Judge must ascertain the claimant's intent behind the statement. With the compilation of digital records and proliferation of social media, more information regarding the claimant is accessible to employer/carriers. As such, misrepresentation becomes an even more important issue in workers' compensation cases. Because these misrepresentation cases can be so fact specific, this provision in Chapter 440 continues to evolve.

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To Change or Not to Change.

By Mark Glaser and Shari Gegerson Hall

To change or not to change, that is one of the most common questions in workers' compensation. Florida Statute 440.34(2)(f) allows an employee the opportunity for a one time change of physician. In a line of recent decisions, the First District Court of Appeal has helped clarify how the one time change operates. The purpose of this article is to discuss the ins and outs of the one time change statute and to highlight the various strategies and pitfalls surrounding its use.

I get a one-time change of physician. What does that mean?

Section 440.13(2)(f) provides that "upon the written request of the employee, the carrier shall give the employee the opportunity for one change of physician during the course of treatment for any one accident. Upon the granting of a change of physician, the originally authorized physician in the same specialty as the changed physician shall become deauthorized upon written notification by the employer or carrier. The carrier shall authorize an alternative physician who shall not be professionally affiliated with the previous physician within 5 days after receipt of the request. If the carrier fails to provide a change of physician as requested by the employee, the employee may select the physician and such physician shall be considered authorized if the treatment being provided is compensable and medically necessary."

How long does the employer/carrier have to respond?

When the 5 day provision for the one-time change was introduced, there were opposing arguments regarding whether the carrier had 5 business days versus 5 calendar days to respond. The employer/carriers would look to the Florida Rule of Civil Procedure and Florida Rule of Judicial Administration which allowed for calculation based on business days since the number of days to respond was under 7. In addition the date of receipt was not included. (Florida Rule of Judicial Administration Rule 2.514). However, the First District, in Hinzman v. Winter Haven Facility Operations, LLC, 109 So.3d 256 (Fla. 1st DCA 2013), was clear in pointing out that the legislative intent was to limit the responding time to 5 calendar days based on the use of language that did not qualify otherwise as was done in other parts of Florida Statute 440.13. They point to their own prior ruling that if the statutory language is clear and unambiguous, the courts should rely on the plain statutory language rather than speculate regarding the intent, Germ v. St. Lukes's Hospital Association, 993 So.2d 576, 578 (Fla. 1st DCA 2008).

What is considered a valid written request for a one time change?

The question then became what would be considered a valid written request. We now know that the employer/carrier response to the request is to be considered in determining whether the request was sufficient to put the employer/carrier on notice of the one-time change request. If the employer/carrier responds in a timely manner, then the response was sufficient. The dispute arises when the employer/carrier does not timely respond and the form of the request may need to be explored. In Gonzalez v. Quinco Electric, Inc., 171 So. 3d 153 (Fla. 1st DCA 2015) the Court held that a "post-petition document that, according to its title and on its face appeared to have a different purpose" is not sufficient to put the employer/carrier on notice. In that case the Petition for Benefits was the claimant's counsel appearance in the matter. Three weeks later he filed a Notice of Appearance which on the first page appeared to be a standard Notice of Appearance. However, on the second page there was language indicating it was "a request for a one-time change of treating physician pursuant to Section 440.13(2)(f)". The Judge of Compensation claims found that the Notice of Appearance did not trigger the employer/carrier obligation to authorize an alternative physician. The First District agreed and stated that, based on the express intent of the worker's compensation system to ensure the prompt delivery of benefits, a one-time change request should not be inserted into a document that appears to have a different exclusive purpose. They stated that the request "should be readily apparent, unobscured, and unambiguous" which would be sufficient to place the employer/carrier on notice of the request. The court cautioned against "inappropriate sharp practice and gamesmanship" which they consider to result in needless disputes.

Additionally, the timing of the request may factor into the determination. Sending a request on December 23rd, the day before a holiday, resulting in the employer/carrier having slightly more than one business day to respond "smacks of gamesmanship". Zekanovic v. Am. II, Corp., 208 So. 3d 851 (Fla. 1st DCA 2017). This analysis was not necessary to render their decision in that matter. However, this may be exactly why we should take note of the language since the Court took the time to recognize and negatively comment on their opinion of this practice.

Unanswered questions?

We do not have any specific ruling or guidance regard-

• *To Change – continued*

ing whether to count the date of receipt in the 5 calendar days. However, in Zekanovic, 208 S. 3d at 852, the court mentioned that the carrier would have only had "little more than one business day to respond". December 23, 2015 was a Wednesday. December 24th and December 25th may not have been business days depending on a company's Holiday Calendar. In addition, many physician offices are closed on those days. December 26th and 27th were Saturday and Sunday, respectively. December 28th was the fifth day and a Monday. It appears that the court was not counting the date of receipt in their calculations. Would receipt at 4:59 pm change the determination of whether the date of receipt should be included in the calculation of the 5 calendar days? The court was clear that any modification to business days versus calendar days is a policy consideration that should be addressed by the legislature.

After the employee has made the written request for the one time change of doctor, whom does the employer/carrier need to notify of their one time change selection?

In Hmshost Corp. v. Frederick, 102 So.3d 668 (Fla. 1st DCA 2012), the employee requested a one-time change of doctor when a written request was made via a petition for benefits. The employer/carrier informed the claimant of a particular doctor's name within 5 days of receiving the request, but did not inform the doctor that he was authorized within 5 days. The JCC concluded that the alternative physician must be notified of his authorization in order to satisfy the statutory mandate of the one-time change provision. The First District Court of Appeal reversed finding that the employer/carrier's naming of the alternative doctor within 5 days of receiving the request satisfied the provisions of section 440.13(2)(f).

However, in Bustamonte v. Amber Constr. Co., 118 So.3d 921 (Fla. 1st DCA 2013), a request for a one-time change was sent to the adjuster on September 25, 2012. On September 26, 2012, the adjuster responded to the request by stating that he would "send notes to the Orthopaedic Institute to see if one of the orthopedics will assume treatment." On September 28, 2012, the adjuster faxed a letter to Jacksonville Orthopedic Institute along with medical records and advising the Institute that it was authorized to evaluate and treat the claimant and requested that one of the physicians review the medical notes and that they schedule an appointment for the claimant. A copy of the fax to Jacksonville Orthopedic Institute was never sent to the employee or his attorney. On October 5, 2012, an appointment letter was mailed to the employee's attorney advising of an appointment with Dr. Kaplan scheduled for October 19, 2012. The claimant responded stating that the request was not provided within 5 days of the written request. The Judge of Compensation Claims found that the adjuster timely authorized the one-time change via the fax to the doctor's group dated September 28, 2012. The First District Court of Appeal reversed and remanded the case finding that at the time the adjuster sent the fax to the physician group, the adjuster did not know whether they would agree to undertake treatment of the claimant. Furthermore, the claimant was not informed of the name of a specific physician until October 5, 2012. The court went on to say that the unilateral notice to Jacksonville Orthopedic Institute was not sufficient to comply with Section 440.13(2)(f).

What happens if the carrier does not authorize the one time change within five business days? The answer depends on what the employee does next.

In Harrell v. Citrus County School Board, 25 So.3d 675 (Fla. 1st DCA), on October 9, 2008, the employee filed a formal grievance form requesting a change of orthopedist. On October 14, 2008, the employer or carrier responded stating that they agreed to authorize a one-time change of orthopedic doctor, and the employer/

• *To Change – continued*

carrier was in the process of scheduling the appointment, and they would advise the employee of the date and time of the appointment, but no doctor was named. On October 28, 2008, the employer/carrier sent a second letter to the employee advising the employee of the date and time of the appointment with Dr. Parr. The employee filed a petition for benefit requesting authorization of Dr. Simon. The employer/carrier responded to the petition indicating they had timely authorized the one time change in orthopedist. Ultimately, the JCC found that the industrial accident was not the major contributing in cause of the claimant's symptoms and denied the request for the one-time change. The First District Court of Appeal found that simply acknowledging a claimant's statutory entitlement to the one-time change is not sufficient. Section 440.13(2)(f) requires the employer/carrier to name at least one physician not professionally affiliated with previous physician within 5 days of the employee's written request. Failure to do so entitles the employee the option of selecting the one time change of physician.

While the failure of the employer/carrier to select a specific physician within 5 days provides the employee the option of selecting an alternative treating physician, the employee may waive their right to make that selection. Pruitt v. Southeast Personnel Leasing, Inc., 33 So.3d 112 (Fla. 1st DCA 2010). On November 14, 2008, the employee filed a petition for benefits seeking among other things a request for an alternative treating physician. The parties attended mediation and the employer/carrier agreed to provide the employee with an alternative treating physician and stipulated to the employee's counsel's entitlement to attorney fees for securing the benefit. The agreement failed to identify a specific alternate physician. Two days after the mediation the employer/carrier authorized a new physician of their choosing. The employee attended several appointments with the alternative physician. That physician ultimately determined that the workplace accident was no longer the major contributing cause of the need for any additional treatment. At the final hearing, the employee argued that he had the right to make the selection of the alternative provider. The JCC found that although the employer/carrier did not timely respond to the request for the one time change the employee never selected an alternative physician even as of the date of the final hearing. The employer/carrier had complied with mediation agreement by authorizing an alternative physician. Accordingly, the JCC denied the employee's request to select the one time change of treating physician. On appeal, the Court agreed that the employee has an absolute right to a one-time change of treating physician, but the statute does not give the employee an absolute right to select the alternative physician. The employee only has the "option" of selecting the physician if the employer/carrier does not timely authorize the alternative physician. However, if the employee fails to exercise that option, he or she may waive the right to select the alternative physician. Since the employee failed to select an alternative physician, the employee acquiesced in the employer/carrier selection to the alternative physician and by attending the appointment the claimant waived his right to make the selection.

If the employer/carrier does not authorize the one time change within 5 days, then the employee has the option of selecting the alternative provider, but for how long?

In Gadol v. Masoret Yehdit, Inc., 132 So.3d 939 (Fla. 1st DCA 2014), the employee made a written request for a one-time change of physician on October 22, 2012. On October 29, 2012, the employer/carrier attempted to make arrangements with Dr. Berkowitz, but his office declined. The employer/carrier informed the claimant of their efforts. On November 12, 2012, the employer/carrier informed the employee of an appointment with Dr. Sheikh, which is 22 days later. The employee's counsel informed the employer/carrier that the employee would not be attending the appointment. Subsequent thereto, a petition for benefits was filed seeking the right of the employee to make the one-time doctor change selection, but did not identify the one-time change selection until another 22 days after the employer/carrier authorized an alternative physician, 44 days total. The JCC ruled that upon the expiration of the 5 days following the written request, the employee maintains the right to select the change of physician up until the moment the employer/carrier authorizes an alternative physician at which time the right is lost. The First District Court of Appeal acknowledged that an employee could waive the right to select an alternative physician but did not give any specific time parameters when that would occur. However, they previously held in earlier cases that the employee's naming of a doctor 41 days after requesting a one-time change and 22 days after the employer/carrier authorized an alternative physician, and where the employee did not attend an appointment scheduled with the employer/carrier's choices, does not constitute such waiver.

Does an employee have a right to select a physician in a different specialty than that of the original authorized physician?

The answer to that question was addressed by the First District Court of Appeal in Retail First Insurance v. Davis, 207 So.3d 1035 (Fla. 1st DCA 2017). The claimant had requested a one-time change of physician to an orthopedic. The claimant at the time of the request was treating with a family practice physician. The JCC found that the employer/carrier's failure to authorize the change of physician within 5 days allowed the employee to select a physician of their choice. The JCC relied on the first sentence of the statute which said that the "em-

• *To Change – continued*

ployee may select the physician [regardless of specialty] and such physician shall be considered authorized if the treatment being provided is compensable and medically necessary". The First District Court of Appeal found that the Judge's interpretation of the statute failed to account for the second sentence of Section 440.13(2)(f) which discusses the deauthorization of the originally authorized physician in the same specialty. "Upon the granting of a change of physician, the originally authorized physician in the same specialty as the changed physician shall become the authorized physician upon the written notification by the employer or carrier." The First District Court of Appeal found that the alternative physician must be in the same specialty as the original authorized physician.

Does an employee have a right to a one-time change if they have never seen the authorized physician?

The answer is no according to Butler v. Bay Center/ Chubb Insurance Company, 947 So.2d 570 (Fla. 1st DCA 2007). In this case, the claimant filed a petition seeking authorization of a pain management physician. The JCC was required to determine whether the employee could request a one-time change in her treating physician without first being treated by the authorized physician. The Judge found that the employee was not entitled to the one-time change. The First District Court of Appeal held that the Legislature's use of the language "change…. during the course of treatment" clearly indicates that the employee must be currently receiving treatment by the physician before she may request a "change". The court went on to say that logically, if a claimant never even attended the initial appointment with the authorized physician, then she cannot "change" from a physician that she was never treated by the physician. Therefore, before requesting at another authorized physician, an employee must at least begin treatment with the physician that the employee seeks to change.

Conclusion

The one time change is commonly used and there are many different nuances. We expect further clarification will continue as the litigation over this issue evolves. As long as the one time change provision remains the only means for an employee to get the right to select a physician of their choice, we will continue to see the case law develop in this area.

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Major Contributing Cause and 120 Day Rule

By Brendan McGettigan

As the case law on major contributing cause has developed, the relationship between major contributing cause and the 120 day rule has been a source of vital importance as well as a common area of dispute. Pursuant to F.S. §440.09(1), an employer must pay compensation or furnish benefits if an employee suffers an accidental injury or death arising out of work performed in the course and scope of employment. The accidental injury must be the major contributing cause of any resulting injuries. "Major contributing cause" is defined as the "cause which is more than 50 percent responsible for the injury as compared to all other causes combined which treatment or benefits are sought."

The statutes relevant to the 120 day rule are §440.192(8) and §440.20(4). As per §440.192(8), "within 14 days after receipt of a petition for benefits by certified mail, the carrier must either pay the requested benefits without prejudice to its right to deny within 120 days from receipt of the petition or file a response to petition…." If a carrier fails to deny compensability in accordance with §440.20(4), the carrier has accepted the employee's injuries as compensable, unless it can establish material facts relevant to the issue of compensability that could not have been discovered through reasonable investigation within the 120-day period. Pursuant to §440.20(4), if a carrier is uncertain as to its obligations concerning an accident, the carrier shall initiate payment and continue to provide benefits while investigating compensability. The carrier is required to send written notice to the employee that it has availed itself of the right to pay and investigate the claim. A carrier that fails to deny compensability within 120 days after the initial provision of benefits or payment of compensation waives the right to deny compensability, unless the carrier can establish material facts relevant to the issue of compensability that it could not have discovered through reasonable investigation within the 120-day period. *See Mims v. Confederated Staffing*, 940 So. 2d 518 (Fla. 1st DCA 2006).

Major contributing cause applies to both the initial determination of compensability, as well as to the entitlement to a specific benefit. Once a claimant has established compensability of an injury, an Employer/Carrier (or "E/C") cannot challenge the causal connection between the work accident and injury. Notwithstanding, the Employer/Carrier can contest the causal connection between the compensable injury and the need for specific treatment. See *Engler v. American Friends of Hebrew Univ.*, 18 So. 3d 613 (Fla. 1st DCA 2009). The 120 day rule only involves the initial determination of compensability of an accident and injury.

In *Checkers Restaurant v. Wiethoff*, 925 So. 2d 348 (Fla. 1st DCA 2006), the Judge of Compensation Claims determined that the Employer/Carrier was estopped from denying an employee's request for additional treatment even though the employee's pre-existing condition was the major contributing cause of the need for further treatment. The 1st DCA noted that there was a distinction between the concept of compensability and a worker's entitlement to benefits as those terms are contemplated in section 440.20(4). *North River Ins. Co. v. Wuelling*, 683 So. 2d 1090 (Fla. 1st DCA 1996). The waiver provision of section 440.20(4) pertains solely to the concept of compensability. If an Employer/Carrier fails to deny compensability, the E/C is only estopped from denying that there was a work related accident and related injury. While the Employer/Carrier was precluded from contending that there was no industrial accident, the Employer/Carrier could challenge the claimant's entitlement to benefits on the basis that the industrial accident was not the major contributing cause of the claimant's need for further treatment.

In making a determination as to when the 120 day period commences, the provision of benefits or payment of compensation by the Employer/Carrier controls. In the context of medical benefits, the "initial provision of benefits" occurs on the date a claimant visits an authorized physician. *Osceola County School Board v. Arace*, 884 So. 2d 1003 (Fla. 1st DCA 2004). In *Russell Corp. v. Brooks*, 698 So. 2d 1334 (Fla. 1st DCA 1997), the Employer/Carrier failed to file a notice of denial after receiving a petition for benefits. The Judge of Compensation Claims awarded all requested medical and indemnity benefits due to said failure. The 1st DCA noted that despite failing to file a denial, the Employer/Carrier did not invoke the pay and investigate provisions of §440.20(4). The failure to file a denial did not foreclose the Employer's/Carrier's right to contest compensability.

• *Asserting Work Product – continued*

As the Employer/Carrier did not provide benefits, the pay and investigate rule was inapplicable.

In the event that an Employer/Carrier has failed to deny compensability within 120 days from the initial provision of benefits under Chapter 440, the Employer/Carrier can only contest compensability if it can establish material facts relevant to the issue of compensability that it could not have discovered through reasonable investigation within the 120-day period. The Employer/Carrier has the burden of demonstrating the material facts that could not have been discovered through reasonable investigation. *Public Storage v. Galano*, 894 So. 2d 287 (Fla. 1st DCA 2005)

In *Hunt v. Exxon Co. USA*, 747 So. 2d 966 (Fla. 1st DCA 1999), the Employer/Carrier denied compensability after the expiration of the 120 day pay and investigate period on the basis that physicians who treated appellant's physical injury testified in deposition that they could not state with certainty that repetitive trauma at work caused her condition. The record established that the Employer/Carrier failed to ask the treating physician during the 120 day period whether the injury was caused by claimant's job duties. The 1st DCA found that the Employer/Carrier failed to establish material facts relevant to the issue of compensability that could not have been discovered through reasonable investigation within the 120-day period. Employer/Carrier could not deny compensability.

In *Willis v. Publix Super Mkts., Inc.*, 871 So. 2d 941 (Fla. 1st DCA 2005), the Employer/Carrier investigated the claimant under the 120 day pay and investigate rule, but did not obtain an independent medical examination until the 123rd day. The Employer/Carrier ultimately denied compensability on the 130th day based upon the opinions of the examiner and argued that there were material facts that could not have been discovered during the 120 day period. The 1st DCA rejected the E/C's contention as the delay in obtaining a physician's opinion did not lengthen the 120 day period.

The failure to deny within 120 days only impacts the ability of an Employer/Carrier to deny the compensability of an accident and injury. As the 1st DCA noted in *Cespedes v. Yellow Transportation, Inc.*, 130 So. 3d 243 (Fla. 1st DCA 2013), once compensability of an injury is established, Employer/Carrier cannot contest that the accident is the major contributing cause of the injury. In *Jackson v. Merit Elec.*, 37 So. 3d 381 (Fla. 1st DCA 2010), the claimant injured his left knee in a compensable motor vehicle accident in 1984. He subsequently developed back pain in 2003 and filed a petition for benefits in 2007 seeking compensability of his low back condition. The Employer/Carrier subsequently stipulated to compensability of the claimant's back and authorized a physician, who opined that the claimant's back pain was due to a pre-existing condition and not the industrial accident. The Employer/Carrier denied treatment for the back and the Judge of Compensation Claims found that there was no causal connection between the treatment recommended for claimant's low back and the industrial accident. The 1st DCA found that as the parties stipulated that the back was a compensable injury, it was necessary for the Employer/Carrier to demonstrate a break in the causation chain, such as the occurrence of a new accident or that the requested treatment was due to a condition unrelated to the injury which the Employer/Carrier had accepted as compensable. The Employer/Carrier failed to meet its burden in demonstrating a break in the chain of causation, so medical treatment was authorized.

In *Sierra v. Metropolitan Protective Services*, 188 So. 3d 863 (Fla. 1st DCA 2015), the Employer/Carrier accepted compensability of a workplace accident. The court noted a "break" could not be proven with evidence that the accepted compensable injury never met the major contributing cause standard in the first place. As stated in *Perez v. Southeast Freight Lines, Inc.*, 159 So. 3d 412, 413-14 (Fla. 1st DCA 2015), once compensability of an injury is established, the Employer/Carrier has the burden to demonstrate "a 'break' in the causation chain" and that under the major contributing cause standard, standard "a 'break' is understood to occur when the work-related cause drops to 50% or less of the total cause of the need for the requested benefits".

CONCLUSION

While there is interchange between the 120 day rule and major contributing cause, the 120 day rule only requires an Employer/Carrier to deny compensability of an accident and injury within 120 days from the initial provision of benefits. The parties must remain cognizant as to the specific injury accepted as compensable. Once compensability has been established, the Employer/Carrier cannot assert that the compensable injury never met the major contributing cause standard. Instead, the Employer/Carrier must demonstrate a break in the causation chain, such as the occurrence of a new accident or that the requested treatment was due to a condition unrelated to the compensable injury.

Brendan McGettigan graduated from Barry University in 2001 with a degree in political science. He received his Juris Doctor from The University of Missouri-Kansas City in 2005 and was admitted to practice law in Florida in 2006. Brendan practices solely in the area of workers' compensation and has served as in-house counsel with Zenith Insurance Company since 2006.

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