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LIABILITY CASE LAW UPDATES

Eleventh Circuit finds no bad faith as a matter of law in multiple competing claims case

In Mesa v. Clarendon National Ins. Co., 799 F. 3d 1353 (11th Cir. 2015), the Eleventh Circuit Court of Appeal considered an appeal from the Federal Southern District of Florida's final summary judgment entered in favor of Clarendon in a third-party bad faith action. In Mesa, the claimant was one of four injured parties involved in an auto accident in which a permissive user was driving a vehicle owned by Clarendon's insured. Bodily injury limits were $10/20k.

The first notice of the accident came from the claimant's attorney, and while it included photos of the claimant in his hospital bed, it did not include a demand for Clarendon's policy limits. Clarendon opened a claims file that day and did not contest the issue of liability. Four days later, Clarendon assigned third-party administrator RAC to adjust the claims and RAC, in turn, hired defense counsel to defend the insured.

Defense counsel immediately contacted the claimant's counsel, who advised that Mesa would not take less than the per person limits of $10k. Clarendon had already identified the other three (3) potential claimants and defense counsel had been notified that all would be making claims. Defense counsel sent a letter to each claimant's counsel acknowledging that the liability limits were insufficient to satisfy all four (4) claims and suggesting that the parties attempt a global settlement. Defense counsel requested that all of the claimants advise him if they agreed to a global settlement or thought it would be helpful. None of the claimants objected, and two of the four specifically agreed. Mesa, the claimant, filed suit, but did not serve it on Clarendon's insured and his counsel never mentioned that suit to defense counsel, although they had a phone conversation after suit had been filed. In the meantime, because Mesa would not accept less than the per person limits, defense counsel hand-delivered a check for $10k and offered to further compensate Mesa for any incidental expenses, but Mesa refused to settle.

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Clarendon advised its insured Zelaya that Mesa filed suit and that it was attempting to settle it. The carrier did not, however, advise Zelaya that he could be exposed to an excess judgment. However, when defense counsel met with Zelaya in person to discuss the status of the claim, defense counsel informed him of his potential personal exposure. Ultimately, an excess judgment of $750,000 was rendered against Zelaya.

Mesa filed the bad faith claim in state court and Clarendon removed it to federal court. The District Court granted summary judgment in Clarendon's favor and that judgment was affirmed by the Eleventh Circuit. In light of the foregoing facts, the appellate court agreed with the Southern District that Clarendon's decision to pursue a global settlement was consistent with its duty of good faith and that it was not unusual for settlement negotiations to last several months.

With respect to Mesa's argument that Clarendon breached its duty to good faith to its insured by failing to immediately advise him as to the possibility of an excess judgment, the Court noted that this alleged bad faith was not the legal cause of the excess judgment and it was therefore immaterial. The Court held that "while such a claim is indubitably supported by the facts in the record, it demonstrates at best a need for Clarendon to augment its claims practices, not that Clarendon's actions rose to the level of bad faith." Because Clarendon was diligent in attempting to settle the claims against its insured and there was no causal connection between Clarendon's actions and the excess judgment rendered against the insured, the appellate court agreed with the trial court that no reasonable juror could conclude that the carrier acted in bad faith.

* * *

Fifth District holds that Plaintiff's judgment should be reduced by the verdict awarded for pain and suffering and lost wages because Plaintiff committed a fraud on the court

In Jimenez v. Ortega, 179 So. 3d 483 (Fla. 5th DCA 2015), the Fifth District Court of Appeal addressed the issue of whether the trial court erred in refusing to dismiss Plaintiff's claims for pain and suffering and loss of earnings after the Plaintiff gave false or misleading answers in his depositions.

In this case, the defense did not contest negligence or the Plaintiff's medical expenses or property damage claims and only the Plaintiff's claims for lost wages and pain and suffering were in dispute. During the pendency of the claim, the Plaintiff was deposed three times and the defense hired an investigator to conduct surveillance, which disclosed that the Plaintiff was not as injured as he claimed to be. In his second deposition, the Plaintiff had to be prompted by his attorney to clarify the extent of his injuries and at his third deposition, six years later, his attorney requested that they take a break, after which the Plaintiff revised several of his prior answers. After that deposition, the Plaintiff's counsel filed an errata sheet further revising his client's deposition testimony.

The case proceeded to trial on the issue of damages, at which the Plaintiff admitted that he lied during his depositions. At the conclusion of that testimony, defense counsel moved to dismiss the case on the ground that the Plaintiff had perpetrated a fraud on the court. The trial court was concerned about dismissing the entire claim given that liability was undisputed and the Plaintiff had legitimately suffered some economic damages, and defense counsel alternatively suggested that the court dismiss the claims relating to the fraud, namely the Plaintiff's pain and suffering and lost wage claims. The trial court permitted the trial to

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continue and after the jury awarded the Plaintiff more than $300,000 for these claims, the trial court denied the motion to dismiss and entered judgment in the Plaintiff's favor for the entire amount of the judgment.

On appeal, the Fifth District found that the Plaintiff's lies were pervasive and significant and that, by their very nature, calculated to interfere with the judicial system's ability to impartially adjudicate the matter. The Court noted that the Plaintiff's claim relied almost entirely on his truthful reporting of his pain, the limits on his activity and the need for assistance in his daily activities, claims which, by their nature, are difficult to quantify and to defend against. The Court also noted that, but for the defense counsel's hiring of an investigator, the Plaintiff's lies would not have been uncovered.

On appeal, the Plaintiff's counsel only argued that Florida's public policy favors the adjudication of claims on their merits, but he did not otherwise dispute the nature and extent of his client's misrepresentations. Counsel also argued that since these misrepresentations were revealed at trial and the jury had the opportunity to consider them during its deliberations, the defendant was in the same position he would have been had the Plaintiff never corrected his falsities. In response, the appellate court stated, "[t]his is nonsense. Consequences provide incentive for a party to be truthful at the outset."

Having said that, the Court held that since liability was admitted and property loss and medical expenses undisputed, only the Plaintiff's pain and suffering and lost wage claim should be dismissed. Accordingly, the court reversed the final judgment for a reduction in the amount of damages awarded on these claims, but otherwise affirmed the remainder of the judgment.

* * *

Medical Malpractice insurer's timely tender of its policy limits barred bad faith claim against it for failing to settle, but did not bar action alleging bad faith in making an offer to arbitrate which entailed admitting liability without making the offer contingent on a limitation on damages

The First District Court of Appeal reversed a final summary judgment in favor of the insured's malpractice insurer on the doctor's bad faith claim against the carrier for its failure to attempt to limit the damages awarded against the doctor when it agreed to arbitration and an admission of liability. In Samiian, M.D. v. First Professionals Ins. Co., Inc., 40 Fla. L. Weekly D2656c (Fla. 1st DCA, Dec. 1, 2015), Dr. Samiian was sued for medical malpractice relating to the death of one of his patients after a liposuction procedure.

In this case, on receipt of the Decedent Estate's Notice of Intent to Initiate Litigation, FPIC hired defense counsel to conduct a presuit investigation, after which FPIC tendered policy limits to the personal representative's attorney. Two days later, defense counsel offered to submit the case to binding arbitration, although counsel clarified that FPIC was not altering its offer to settle for policy limits. The offer to arbitrate was not contingent on a limitation of damages. The personal representative accepted the offer to arbitrate and ultimately, an arbitration panel awarded the Estate and survivors $35,315,789.00.

Dr. Samiian sued FPIC alleging that it acted in bad faith in handling the claim. FPIC moved for final summary judgment on the grounds that 1) it timely tendered its policy limits in response to the Notice of Intent, pursuant to the Safe Harbor provisions in Florida Statute 766.1185(1)(a)1, which provides the carrier with 210 days within which to tender its policy limits in response to a Notice of Intent and 2) that FPIC was not responsible for the decision

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Focus on: Bad Faith & Extra Contractual Litigation

Litigation Defense in Bad Faith and Extra-Contractual Claims

The attorneys at Conroy Simberg regularly represent insurers facing bad faith and extra contractual claims. We combine our decades of legal experience with a comprehensive understanding of the operations of the insurance industry in order to vigorously defend our clients involved in first and third-party common law and statutory bad faith claims.

Insurers facing bad faith and extra-contractual claims seek out our firm because of our ability to provide a proper risk analysis. We regularly counsel and represent insurance companies involved in disputes with policyholders alleging both the wrongful denial of policy benefits and the refusal to settle third-party claims. Our attorneys also defend insurers against extra-contractual claims encompassing all forms of insurance claims and coverage disputes, including:

- Automobile
- Construction
- Directors and Officers Liability
- Employment
- Environmental
- First Party Property and Coverage
- General Liability and Casualty
- Medical
- Mass Tort
- Premises Liability
- Products Liability
- Professional Liability

Our attorneys counsel with our insurer clients to carefully review, investigate and evaluate these types of claims. We thoroughly explain the state-specific laws and statutes to our clients and take the time to fully understand their business goals and operations. Our team of legal professionals strives to provide clients with timely information needed to make well-founded decisions in their case.

When handling a claim, our attorneys use their understanding of the legal environment surrounding insurance coverage and policy issues to guide our clients through complicated legal processes and procedures. We take a proactive approach and work to obtain a favorable disposition these claims as early as possible. In each case, our assigned team of legal professionals carefully reviews all documentation and identifies and interviews key individuals and personnel. When necessary, we also consult with our network of experts to further analyze and evaluate critical factors in the case, including the insured's liability, the extent of the recoverable damages and potential costs and expenses.

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to arbitrate, which was made by the insured in consultation with his legal team, independently of FPIC.

The trial court granted summary judgment on the first ground, and determined that subsection (2) of the statute, which governs bad faith claims predicated on actions other than a failure to tender, did not apply. The trial court found that there was no claim under subsection (2) because Dr. Samiian made the decision to arbitrate after consulting with his defense counsel. The trial court, however, noted that FPIC'S adjuster also participated in discussions relating to the decision to arbitrate.

The appellate court affirmed the trial court's summary judgment to the extent that it found that the carrier timely tendered its policy limits during the safe harbor period. The court, however, reversed the judgment finding that the insurer could be found liable in bad faith under Florida Statute 766.1185(2), which sets forth ten (10) factors that a court must consider in a bad faith action brought under that subsection. The Court noted that there was a question of fact as to whether Dr. Samiian's decision to arbitrate was, in fact, unilateral or whether FPIC participated in that decision, and whether that decision was in Dr. Samiian's best interests in light of his counsel's waiver of all of his defenses without obtaining a limitation on the doctor's potential liability.

* * *

Fifth District finds that attorneys fees awarded against insured were covered under insured's policy where the policy covered "all costs taxed against an insured" in any suit defended by the carrier

Mid-Continent Cas. Co. v. Treace, 41 Fla. L. Weekly D60c (Fla. 5th DCA, Dec. 31, 2015) dealt with the issue of whether attorneys' fees awarded against an insured in a construction defect suit would be covered under the insured's CGL policy. The policy in question contained a Supplementary Payments provision requiring MCC to pay "all costs taxed against the insured" in any suit the carrier defended. Because the policy did not define the term "costs" to exclude attorneys' fees, the appellate court found those fees covered under the policy.

* * *

Federal Court finds that trial court properly excluded from evidence in bad faith trial a settlement opportunity letter which would have required the carrier to enter into a consent judgment in excess of its policy limits

In Kropilak v. 21st Century Ins. Co., 806 F.3d 1062 (11th Cir., 2015), the Eleventh Circuit Court of Appeal affirmed the District Court's order excluding from evidence at trial a copy of a letter to the insurer by the claimant offering to enter into a consent judgment in excess of the insured's policy limits. In this case, the insured had $10k in policy limits, and the carrier tendered those limits 37 days after receipt of the claim, which tender was rejected. The jury rendered a judgment against the insured in the amount of $173,097.07. The insured assigned the claimant the proceeds of his bad faith claim against the carrier and agreed to cooperate with the claimant in pursuing that action in return for the claimant's agreement not to execute on the excess judgment.

The bad case was filed and proceeded to trial in federal court. The carrier moved in limine to exclude from evidence a settlement letter in which the claimant offered to enter into a consent judgment with the carrier for $150,000, well in excess of 21st Century's policy limits. The trial court granted the motion, finding that the letter

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was irrelevant and more prejudicial than probative of whether the carrier was in bad faith in failing to tender its policy limits earlier than it had. The jury in the bad faith claim found that 21st Century had acted in bad faith, but found in favor of the carrier on its affirmative defense that there was no realistic possibility of settling the plaintiff's claim within the policy limits. Accordingly, the trial court rendered a judgment in the carrier's favor.

On appeal, the Plaintiff argued that the trial court erred in granting the motion in limine precluding the argument that the carrier was also in bad faith in refusing to enter into a consent judgment in excess of its policy limits. The appellate court disagreed, finding that a Florida insurer has no duty to enter into consent judgment with the Plaintiff in excess of its policy limits.

* * *

Trial Court did not err in finding insurer jointly and severally liable with the insured for the Plaintiff's taxable litigation costs, in light of the policy provision providing coverage for "other reasonable expenses" incurred at the carrier's request; appellate court certifies conflict

In New Hampshire Indemnity Co. v. Gray, 177 So. 3d 56 (Fla. 1st DCA, 2015), the appellate court addressed the issue of whether the insured's policy provided coverage for a $135,000 cost judgment rendered against the insured after the case went to trial and the insured was found liable to the extent of $2.3 million.

The insured's policy required the carrier to cover Supplementary Payments, including reasonable expenses "incurred at [the insurer's] request". The appellate court noted that there is currently a conflict between FIGA v. Johnson, 654 So. 2d 239 (Fla. 4th DCA 1995), in which the Fourth District found FIGA liable to cover litigation costs taxed against an insured after the insured's liability carrier chose to litigate the claim, and Steele v. Kinsey, 801 So. 2d 297 (Fla. 2d DCA 2001), in which that Court found that an attorneys' fee and cost judgment rendered against the insured under a Proposal for Settlement was not covered under a policy with similar language because the Plaintiff did not incur those expenses at the insured's request. Steele had previously been certified to the Supreme Court based on its conflict with Johnson, but the Supreme Court, after initially accepting jurisdiction, declined to resolve the conflict and discharged its jurisdiction. Thereafter, in reviewing Johnson, the Florida Supreme Court found that under the FIGA statute, FIGA would be responsible for supplementary payment coverage for interest on judgments rendered against the insured, in excess of the policy limits. While noting that Steele was in conflict with Johnson and the Court had previously declined to review Steele, the Supreme Court did not otherwise address the conflict between the two.

Here, the First District found Johnson remained good law and agreed with the Fourth District's observation that it is generally the insurer's choice to litigate and to that extent, costs taxed against the insured should be deemed "expenses incurred at our request" pursuant to the Supplementary Payments provision in the policy. The Court also noted that the Second District's reasoning in Steele was contrary to the very purpose of purchasing liability insurance and that construing this clause to exclude costs and fees taxed against an insured, who had no control over the litigation, was nonsensical. The Court further observed that the Steele Court's interpretation of the policy language was contrary to the purpose of the Offer of Judgment statute, which was intended to discourage excessive or frivolous litigation and permitted a carrier to avoid the consequences of its own decisions by excluding from coverage

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expenses that the carrier itself caused by continuing the litigation, thereby providing the carrier with a financial disincentive to settle on the insured's behalf.

Accordingly, the First District affirmed the final judgment finding NHIC jointly and severally liable with its insured for litigation costs. The Court also certified the case the Supreme Court to resolve the conflict between its decision and Steele.

* * *

Supreme Court finds that evidence of future Medicare benefits is not admissible

The Florida Supreme Court, in Joerg, Jr. v. State Farm Mutual Auto. Ins. Co., 176 So. 3d 1247 (Fla. 2015), reversed the Second District's opinion holding that evidence that the claimant will receive future Medicare benefits is admissible into evidence as one factor that could be considered by the jury in rendering its verdict for future medical expense claims.

The Supreme Court opined that because Medicare retains a right of reimbursement, the Plaintiff would not receive a windfall if that evidence is excluded from the jury's calculation of future medical expenses. In addition, the Court found that such evidence of collateral source benefits was inherently prejudicial to the Plaintiff, especially since some jurors were antipathetic to the notion of what they perceive to be government "handouts". Also of concern is the difficulty in calculating inherently speculative benefits that the Plaintiff has not yet received and may never receive, especially in light of the fact that funding for government services is entirely dependent on legislative action.

Accordingly, the Supreme Court found that the Second District Court of Appeal erred in finding that the trial court should have permitted the introduction of evidence relating to future Medicare benefits potentially available to the Plaintiff, and quashed the appellate court's decision, letting stand the final judgment in the Plaintiff's favor on all damages.

* * *

Fifth District Rules that Emergency Provider Bills are Subject to the Policy Deductible

The Fifth District Court of Appeal issued its Opinion in Mercury Insurance Co. of Florida v. Emergency Physicians of Central Florida, 40 Fla. L. Weekly D2364 (Fla. 5th DCA, Oct. 16, 2015), ruling that policy deductibles must be applied to emergency provider bills.

In 2008, the Florida Legislature added a provision to Section 627.736(4)(c) of the Florida Statutes providing that, upon being notified of an accident, automobile insurers were required to reserve $5,000 of personal injury protection ("PIP") benefits for payment to certain emergency service providers. Although there was nothing in that statute specifically altering the application of the policy deductible, numerous county and circuit courts had ruled that the policy deductible was not to be applied to timely submitted emergency provider bills.

The Fifth District is the first appellate court to address the issue, and it soundly rejected the analysis that had been employed by attorneys for the emergency providers and the lower courts which had accepted those arguments. The Fifth District noted that there was nothing in Section 627.736(4)(c) that abrogated the policy deductibles for emergency providers, and that the Legislature did not amend the deductible statute, Section 627.739(2) of the Florida Statutes.

* * *

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Third District Rules that Failure to Notify PIP Insurer of Provider's Bill Results in no Benefits for PIP or Medical Payments Coverage

In State Farm Mutual Automobile Insurance Co. v. Gonzalez, 178 60. 3d 448 (Fla. 3rd DCA, 2015), the Third District held that, since the insurance company did not receive timely notice of a provider's claim for benefits, there was no entitlement to benefits under either the Personal Injury Protection ("PIP") or Medical Payments ("Med-Pay") coverages of the policy.

The plaintiff, Isabel Gonzalez, was injured on May 27, 2001 when she was struck by a vehicle. She was transported to and received treatment at a hospital emergency room. The hospital did not bill State Farm, but instead billed Gonzalez' health insurer, which paid the $685 bill. Other bills were initially sued upon but thereafter withdrawn by Gonzalez, leaving only the hospital bill for consideration.

Although State Farm received notice of the accident, it did not receive any claim or notice of the hospital's charges as required by Florida Statute § 627.736(5)(d), even though it requested information numerous times. The Third District ruled that, although Florida Statute § 627.736(4)(b) provides that PIP benefits are overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and the amount of same, § 627.736(5)(d) provides that for purposes of (4)(b), "an insurer shall not be considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph." Because there was no statement concerning the hospital's charges which complied with § 627.736(5)(d), the Third District ruled that State Farm had no obligation to pay for the $685 in hospital charges.

Moreover, because the State Farm policy provided that if PIP benefits are not payable, the Med-Pay benefits are not payable because Med-Pay is essentially excess coverage, the Court ruled that the failure to comply with § 627.736 resulted in a complete defense applicable to both PIP and Med-Pay.

* * *

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WORKERS' COMPENSATION CASE LAW UPDATES

JCC abused discretion by denying advance based upon the Claimant's indebtedness pre-dating accident.

Mathis v. Broward County School Board, 2015 WL 9258278 (Fla. 1st DCA 2015). The Claimant requested an advance of $2,000.00 which the JCC denied, concluding that the Claimant failed to show a substantial reduction in wages or the requisite nexus between the need for an advance and the workplace injury. Specifically, although the Claimant was able to show that as a result of the accident she was on unpaid leave and received no income for almost a month, the fact that the JCC denied the motion based upon the fact that the Claimant's indebtedness pre-dated the accident was an abuse of discretion and the denial of the advance was reversed.

* * *

Employer/Carrier paid costs, stipulated to by the parties, do not have to be justified or detailed.

Gobel v. American Airlines, 177 So. 3d 1289 (Fla. 1st DCA 2015). The JCC issued an order denying stipulated litigation costs in the amount of $200.00 payable by the Employer/Carrier. The basis for the JCC's denial was based upon his determination that the Claimant produced no supporting documentation describing the costs and he was unable to determine whether they were truly costs or merely disguised attorney's fees. The First District reversed the denial, noting that 60Q-6-124 (2), Florida Administrative Code and section 440.20(11), permit the parties to stipulate to the payment of attorney's fees and costs without any requirement that the agreed-upon costs be justified or detailed.

* * *

It is improper to focus solely on medical treatment without considering ongoing symptoms when determining whether or not the need for treatment is caused by pre-existing conditions versus a workplace accident

Certistaff v. Owen, 40 Fla. L. Weekly D2754 (Fla. 1st DCA 2015). At issue was the JCC's rejection of the opinion of the EMA that the Claimant's need for a recommended shoulder replacement was his pre-existing condition. The Claimant underwent two surgeries to repair his right rotator cuff and two left shoulder cuff surgeries approximately 8-12 years prior to his work accident. As a result of the accident, the Carrier initially accepted compensability of a right shoulder injury and authorized medical care with Dr. Patterson. After the initial visit with Dr Patterson, the Carrier denied further treatment on the basis that the need for treatment was the Claimant's pre-existing shoulder pathology which included osteoarthritis and rotator cuff arthropathy. In deposition, the Claimant testified that he was not receiving medical care immediately prior to the accident but did admit to ongoing complaints of pain with heavy lifting and taking over-the-counter medication for it. He further testified that he was able to fully perform his job duties with occasional accommodations by the Employer.

The JCC found that although the Claimant had ongoing symptoms, his preexisting condition did not require medical treatment prior to the compensable accident. The JCC further found that all of the physicians agreed that the rotator cuff repair and the pre-existing arthritis were the cause of the need for a shoulder replacement. However, the JCC found that if the compensable injury had not occurred, then the Claimant's

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condition may or may not have progressed to the point of requiring surgery. As such, she concluded that the compensable accident caused the underlying condition to become symptomatic, which in conjunction with the pre-existing condition, resulted in the need for surgery.

The District Court opined that the JCC's error was to focus solely on whether the Claimant was or recently had been undergoing physician-provided medical treatment for his shoulder. In doing so, the JCC excluded the evidence that the Claimant had ongoing symptoms and that the objective medical evidence showed a pre-existing shoulder condition.

Furthermore, the appellate court found that even through the 2013 workplace accident may have been the most recent aggravator of the shoulder problems, the JCC failed to support her rejection of the EMAs opinions by clear and convincing medical evidence.

* * *

The JCC does not have jurisdiction to reduce the amount of a legally sufficient claim for attorney's fees where the Employer/Carrier fails to respond to the Verified Petition in a timely manner

Nelson v. Pharmerica, 40 Fla. L. Weekly D2395 (Fla. 1st DCA, Oct. 22, 2015). The Claimant filed a Verified Petition for Attorneys Fees and Costs to which the Employer/Carrier failed to timely respond due to an inadvertent, clerical error. The Claimant appealed the JCC's Order denying Claimant's motion to strike the untimely response because the Employer/Carrier did not establish a good cause for the late filing. The First District agreed, holding that given this failure, the JCC did have jurisdiction to reduce the amount of the "legally sufficient" claim for attorney's fees.

* * *

Once the 120-day rule results in a waiver of the right to deny a condition, the Carrier cannot deny compensability on the basis that the workplace accident was never the major cause of the condition in the first place

Sierra v. Metropolitan Protective Services, 40 Fla. L. Weekly D2209 (Fla. 1st Sept. 30, DCA 2015). The Claimant worked as a security guard when he was attached by an assailant wielding a knife on April 1, 2012. His physical injuries were minor but he was referred to a psychiatrist or psychologist by the Emergency Room physicians. Upon returning to work and at the Claimant's request, he was transferred to another location. Thereafter, within a few months, he sustained two non-work related injuries, one minor and the other resulting in severe injuries to his right shoulder requiring surgery and after which he did not return to work. In August, 2013, after both subsequent accidents, later he requested medical care relating to his compensable work accident and the Carrier authorized both an orthopedic doctor and a psychiatrist.

In January, 2013, the Claimant was deposed and testified to prior psychiatric care, his two subsequent non-work related accidents, and admitted to receiving psychiatric care, unauthorized, through Medicaid. The Claimant was placed at physical MMI for the laceration to the left wrist on January 22, 2013 without restriction or any impairment. Thereafter, on January 23, 2013 he underwent an initial evaluation with the psychiatrist through workers' compensation who diagnosed PTSD, prescribed medication and recommended psychotherapy. He filled out a DWC-25 indicating that there was no pre-existing condition and that the work accident was the MCC of the psychiatric injury/illness. The Claimant did not return again until he filed a Petition in June, 2013 and at Mediation on June 24, 2013 the Carrier agreed to schedule a follow up with the psychiatrist and provide transportation.

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However, this was not scheduled and on June 4, 2014 a second Petition was filed requesting authorization of the psychiatrist. Although in response to the Petition the Carrier agreed that the doctor remained authorized, at Mediation on September 19, 2014 they only agreed to set an evaluation with the psychiatrist. The Claimant returned to the psychiatrist who noted, via deposition testimony, that his complaints were unchanged as was his diagnosis. In Pre-Trial the Carrier agreed that the psychiatric condition was accepted as relates to the compensable accident but asserted that the Claimant had two non-work related accidents which served to break the chain of causation. In support, the Carrier's IME testified that 75% of his need for treatment was attributable to the second non-work related accident.

At the hearing, the Claimant asserted that the Employer/Carrier waived their right to deny compensability of the PTSD in accordance with section 440.20(4), Florida Statutes (the 120 day pay -and-investigate provision of the statute). While acknowledging this claim, the JCC never made any relevant findings in that regard. Instead, the JCC denied psychiatric care on the basis that the authorized psychiatrist's testimony was not clear and convincing evidence to support the claim. Furthermore, he accepted the opinions of the IME physician.

In reversing and remanding the JCC's decision, the First District explained that a correct analysis of the 120 day pay-and-investigate provisions of the statutes requires the following findings: 1). the date that the E/C first provided benefits for a psychiatric injury; 2). the identity of the specific psychiatric injury for which benefits were provided; and 3). whether the E/C timely denied compensability of the psychiatric injury for which it provided benefits. The First District noted that such analysis may also include whether the E/C can establish material facts relevant to the issue of compensability that it could not have discovered through reasonable investigation within the 120-day period. This analysis is applicable to both issues of whether the compensable injury is the MCC of the need for treatment and whether such treatment is medically necessary. The appellate court further noted that "where the waiver or the right to deny compensability of an identified injury has occurred under subsection 4403.20(4), a later finding that the compensable injury was not caused in major part by the workplace accident in the first instance, will not satisfy the necessary proof that the compensable injury 'no longer' remains the major contributing cause of the need for treatment – or such finding would be, in actuality, a belated way of saying 'the compensable injury was never compensable,' which (assuming the 120-day rule results in waiver) is prohibited under section 440.20(4)."

* * *

It is the Carrier's burden to elicit specific testimony as to pre-existing conditions in order to establish a right to apportionment.

Frankel v. Loxahatchee Club, Inc., 179 So. 3d 384 (Fla. 1st DCA 2015). The Claimant sustained an injury to his right shoulder, thoracic spine and lumbar spine while he was moving furniture. At the time he was 68 years old and admitted to having a prior injury to the shoulder 15-20 before, which resulted in surgery. However, he further testified that he did not receive subsequent treatment for the shoulder after his post-surgical therapy.

After his compensable injury, the Claimant underwent an MRI to the shoulder which revealed degenerative arthritis in the right shoulder which the doctor described as age appropriate; and the Claimant denied receiving any medical care for

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this degenerative condition. The authorized provider opined, and the JCC accepted, that the work accident was 55% responsible for the need for right shoulder surgery; that his prior rotator cuff condition was 25% responsible for the need for surgery and that his degenerative changes were 20% responsible for the need for surgery.

The First District affirmed the portion of the JCC's ruling which allowed the Carrier to apportion 25% of the cost of surgery as relates to the pre-existing rotator cuff condition, noting that the doctor's DWC-25 specifically listed the pre-existing condition as contributing to the medical disorder and stated that the objective relevant findings represented an exacerbation of a pre-existing condition.

However, as to the 20% apportioned based upon the pre-existing degenerative condition, the First District noted that the Carrier never asked the doctor whether the Claimant's degenerative changes were aggravated by the compensable injury. Furthermore, the doctor specifically testified that the degenerative changes were age appropriate. The Carrier was unable to meet its burden to elicit specific testimony or other medical proof that the Claimant's pre-existing degenerative changes were aggravated by the compensable injury. Thus, this portion of the JCC's ruling was reversed and the Carrier's ability to apportion was limited to 25%.

* * *

A Claimant who suffers a compensable injury and receives treatment therefore is entitled to a one-time change in treatment physician as an "absolute right" if properly requested during the course of treatment

Babahm Etovic v. Scan Design Florida, Inc., 176 So.3d 1006 (Fla. 1st DCA 2015). The Claimant appealed the JCC's denial of his one-time change in physician. The Claimant lifted a box at work and as a result of low back complaints, the E/C sent him to a primary care physician. This doctor completed a DWC-25 indicating a diagnosis of radiculitis and stating that the injury/illness for which treatment was being sought was work related, and he was referred to a specialist. The specialist initially saw the Claimant around 5 weeks after the accident and opined that he had a resolving lumbar sprain and pre-existing degenerative disc disease, and in the DWC-25, checked the boxes that this was work-related. On that same date, however, he sent a letter to the Carrier stating that the cause "regarding the lumbar spine" was 60% preexisting condition and only 40% the "workplace injury." Within two weeks, the Carrier issued a Notice of Denial indicating that the industrial accident was not the MCC of the need for treatment. It was agreed that this was a denial of compensability, specifically that there was never a compensable injury.

In its analysis, the First District agreed with the JCC that there must first be a compensable accident and injury before a Claimant is entitled to any benefits under Chapter 440. The JCC failed to recognize the existence of a compensable injury. The DCA explained the concept of compensability as "the occurrence of an industrial accident resulting in an injury" which in the instant matter was a lumbar sprain. The appellate court noted that there was no evidence before the JCC that the sprain was caused by the degenerative disc disease or anything other than work. Because the Claimant suffered a compensable injury and received treatment therefor, he was entitled to a one-time change in treatment physician as an "absolute right" if he made a written request for such during the course of treatment.

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The information in this newsletter has not been reviewed or approved by The Florida Bar. You should know that:

◊ The facts and circumstances of your case may differ from the matters in which results have been provided.

◊ Not all results of cases handled by the firm are provided.

◊ The results provided are not necessarily representative of results obtained by the firm or of the experience of all clients or others with the firm. Every case is different, and each client's case must be evaluated and handled on its own merits.

Cristobal A. Casal and Brian P. Haskell have been named partners in the firm

Cristobal A. Casal, a partner in the Hollywood office, earned his undergraduate degree in History and International Relations, from Northwestern University and his Juris Doctorate from the University of Miami School of Law. Cristobal joined Conroy Simberg in 2007 and has worked in the civil defense field for the entirety of his career and has successfully tried numerous cases to verdict in the fields of premises liability, motor vehicle accident liability and product defect litigation. Cristobal is fully fluent in Spanish as he was born in Ecuador but migrated to Miami at an early age. As part of his international background, Cristobal has visited more than twenty five countries in four continents.

Brian P. Haskell, a partner in the Tampa office, earned his undergraduate degree in Psychology, magna cum laude, from the University of South Florida in 1999. He then received his Masters of Business Administration and his Juris Doctorate, cum laude, from Stetson University College of Law in 2002. He is admitted to practice in all Florida State Courts and the United States District Court for the Middle District of Florida. Brian currently practices in the areas of general liability, commercial and construction litigation, administrative law, long-term care litigation, medical malpractice, personal injury and casualty defense. He is a member of the Hillsborough County Bar Association and has been listed in Florida Super Lawyers Magazine 2010 and 2011 as a "Rising Star", an honor conferred on only 2.5% of the attorneys in the state practicing for less than 10 years.

* * *

South Florida Legal Guide Recognizes Conroy Simberg as a 2016 Top Law Firm and three of the firm's partners as Top Lawyers

We are pleased to announce that our firm has been listed in the Top Law Firm category and three of our South Florida partners have been included in the 2016 edition of the *South Florida Legal Guide*. The Top Lawyer and Top Law Firm listings are published annually and are based on peer nominations. Nominees then are evaluated on accomplishments and individual credentials prior to being named to the list.

- **Jonathan C. Abel** – Medical Malpractice – Defense, Product Liability – Defense
- **Scott D. Krevans** – Insurance Litigation – Defense, Personal Injury and Wrongful Death – Defense
- **Bruce F. Simberg** – Product Liability – Defense, Construction Litigation

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Affirmance of summary judgment obtained

Hinda Klein, the managing partner of the firm's appellate department, was successful before the Second District Court of Appeal in obtaining an affirmance of a summary judgment in a case handled by our Tampa office. The case involved the alleged malpractice of a property surveyor and his company. The trial court granted summary judgment in favor of the defense on the grounds that the claim was barred by the statute of limitations, and the appellate court affirmed on all grounds within a week after the oral argument. The appellate court also issued an order granting appellate attorneys' fees based on a Proposal for Settlement served during the litigation.

* * *

Fifth District Rules that emergency provider bills are subject to the policy deductible

On October 16, 2015, the Fifth District Court of Appeal issued its Opinion in Mercury Insurance Co. of Florida v. Emergency Physicians of Central Florida, Case No. 5D15-1064, ruling that policy deductibles are to be applied to emergency provider bills.

In 2008, the Florida Legislature added a provision to Section 627.736(4)(c) of the Florida Statutes providing that, upon being notified of an accident, automobile insurers were required to reserve $5,000 of personal injury protection ("PIP") benefits for payment to certain emergency service providers. Although there was nothing in that statute specifically altering the application of the policy deductible, numerous county and circuit courts had ruled that the policy deductible was not to be applied to timely submitted emergency provider bills.

The Fifth District is the first district court of appeal to address the issue, and it soundly rejected the analysis that had been employed by attorneys for the emergency providers and the lower courts which had accepted those arguments. The Fifth District noted that there was nothing in Section 627.736(4)(c) that abrogated the policy deductibles for emergency providers, and that the Legislature did not amend the deductible statute, Section 627.739(2) of the Florida Statutes.

The appellate proceeding in the Fifth District was handled by **Diane Tutt** Senior Associate in Conroy Simberg's appellate department and **John Morrow,** Partner in charge of the firm's Orlando Office.

* * *

Homeowner's actions protected by Florida's litigation privilege

A Miami-Dade Judge dismissed *with prejudice* a $30 million lawsuit filed by Prive' developer Gary Cohen against a group of homeowners who are frightening his efforts to build a 160 unit condominium complex on the last undeveloped island in Biscayne Bay. Judge Jerald Bagley granted a motion to dismiss the lawsuit, finding that developer Gary Cohen's lawsuit was an attempt to silence homeowners from exercising their legal rights to challenge the development. Bagley ruled that the homeowners were not bound by an agreement that Cohen himself had created and signed. The Judge also ruled that the homeowner's actions were protected by Florida's litigation privilege and the lawsuit violated the state's Anti-SLAPP statute. Five of the homeowners were represented in the case by Conroy Simberg partner **Dale L. Friedman** who presented the oral argument at the hearing on behalf of all of the Defendants.

Homeowners on Island Estates and Williams Island filed lawsuits last year challenging Cohen's

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plans to erect two condo towers on the last developable island in Biscayne Bay. For more than a decade, Cohen proclaimed that he intended to build just 17 single-family homes on the North Island of Island Estates. The only road leading to the North Island passes through the South Island, where Cohen sold lots to homeowners years ago with the assurance that single-family estate homes would be built on the adjacent north island. The homes built by the homeowners on the South Island are worth millions of dollars.

* * *

Rachel Minetree earns AV rating from Martindale Hubbell

Rachel H. Minetree, the managing partner of the liability division in our Miami office, has achieved the AV® Preeminent™ Review Rating from Martindale-Hubbell thereby attaining the highest possible rating for both ethical standards and legal ability.

* * *

Defense prevails on secondary insured coverage issue

Millard L. Fretland, the managing partner of the liability division in our Pensacola office, won a bench trial on a Specified Medical Event policy where he represented AFLAC. After trial, the Court ruled that the plaintiff was not a covered secondary insured under her mother's policy because she was not defined as such by IRS regulations in force at the time.

* * *

Affirmance of judgment obtained

Diane Tutt, Board Certified Appellate Lawyer in the firm's Appellate Department, was successful in obtaining affirmance of a judgment in the case of Comprehensive Chiropractic Center a/a/o Emanese Mirthil v. State Farm Mutual Automobile Ins. Co., Case No. CACE12-009955, in the Circuit Court (Appellate Division) of Broward County, Florida. The judgment in favor of State Farm, due to the exhaustion of benefits, was affirmed. The appellate court rejected the medical provider's argument that State Farm had improperly paid other providers, thereby improperly exhausting PIP benefits. The provider failed to prove that any of the other payments made by State Farm were improper. In addition to affirming the judgment, the appellate court ruled in favor of State Farm, reversing an order denying State Farm's motion for attorney's fees based on its proposal for settlement. The appellate court ruled that there was no evidence that State Farm's nominal settlement offer was made in bad faith, and its proposal for settlement should therefore have been enforced.

* * *

Defense successfully argued a Petition for Section 22 Modification of a PTD award under the Longshore Act

Christopher Tice, Managing Partner of the Jacksonville office, successfully argued a Petition for Section 22 Modification of a Permanent Total Disability (PTD) award under the Longshore Act. The Administrative Law Judge (ALJ) agreed with the defense that the Claimant's employment as a Union Trustee was evidence of a post-injury wage earning capacity and the stipend paid to the Claimant was "wages" pursuant to the Act. Because of these new findings, the ALJ found that there was a mistake in fact in awarding

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PTD benefits pursuant to the December 23, 2009 Order. The ALJ found that the Claimant was Permanently Partially Disabled as of September 2, 2008 and not PTD. The ALJ reduced the compensation rate after applying the post-injury wage earning capacity. Further, the ALJ agreed to allow the Carrier to recoup the overpayment of benefits from September 2, 2008 to the present.

* * *

Defense prevails on Claimant's appeal from a complete denial of benefits on a statutory employer

Hinda Klein, partner and head of the firm's Appellate department, **Elizabeth A. Izquierdo**, an associate in the appellate department, and **Christopher Tice**, Managing Partner for the Jacksonville office, successfully defended the Claimant's appeal from a complete denial of benefits on a statutory employer defense. In Bru v. Carlton Construction Co./Builder's Insurance Group, the Judge agreed that the Claimant may have been injured on the property, but he was never hired by the uninsured subcontractor. In the absence of an Employer/Employee relationship with the uninsured subcontractor, the General Contractor could not be deemed a statutory employer. The First District upheld the JCC's order without opinion. The Employer/ Carrier is now entitled to seek trial costs against the Claimant.

* * *

Defense prevails on food poisoning claim

Millard L. Fretland, managing partner of the liability division in our Pensacola office, was recently successful in a food poisoning claim which he won on directed verdict after the plaintiff failed to prove her prima facie case.

* * *

Motion for summary judgment granted

Joseph M. Sette, managing partner of the liability division in our Fort Myers office and **Yasmine Kirollos**, associate in the Fort Myers office, recently obtained summary judgment in favor of Target.

The matter arose out of an alleged slip and fall at the Bakery counter at Target in Naples Florida. Plaintiff, an elderly woman while reaching for a piece of cake displayed in the Bakery slipped and fell striking her head and face and falling on her wrist. She sustained multiple injuries including a fractured wrist requiring ORIF, laceration on her forehead requiring stitches, fractured nose and broken ribs. Plaintiff incurred over $70,000 in medical specials. Plaintiff alleged Target failed to maintain the premises in a reasonably safe condition, allowed a dangerous condition to exist, failed to warn of, inspect for, and otherwise operated the business in a negligent manner. Target denied liability given the lack of an identifiable condition and lack of notice of any condition complained of.

The United States District Court, Middle District, Fort Myers Division granted summary judgment in favor of Target. The court noted that at deposition plaintiff was unable to identify any liquid or object to cause her to fall and that plaintiff assumed that there must have been something on the floor which caused her fall. Three Target employees testified of inspecting the floor after the incident and regularly conduct routine visual inspections and clean up any spills. Given the evidence the burden shifted back to the plaintiff to provide evidence of disputed facts which she was unable to do.

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Marc J. Gutterman earns AV rating from Martindale Hubbell

Marc J. Gutterman, partner and chair of the firm's property department in the Hollywood office, has achieved the AV® Preeminent™ Review Rating from Martindale-Hubbell thereby attaining the highest possible rating for both ethical standards and legal ability.

* * *

Motion to exclude testimony of plaintiff's expert witness on diminished value of vehicle is granted

Rodney C. Lundy, partner in the Orlando office, handled a case involving the diminished value of an auto that allegedly occurred following accident related repairs. An expert was issuing opinions to carriers throughout the state these vehicles sustained thousands of dollars in "diminished value" in accident related stigma losses. The court held a Daubert hearing on the reliability of this expert's methodology in calculating diminished value. The judge struck his testimony on the grounds it was not based on sufficient facts, not the product of reliable principles and methods and did not reflect a reliable application of principles and methods to the case at issue.

IF YOU HAVE RECENTLY MOVED, KINDLY SEND US AN E-MAIL WITH YOUR NEW INFORMATION TO: csg@conroysimberg.com

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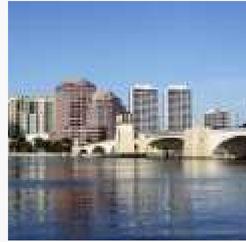

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