LITCHFIELD CAVO LLP
ATTORNEYS AT LAW

David S. Gold, Partner
D 954.628.3015 | Gold@LitchfieldCavo.com
Lynne M. Wilkerson, Esq., Attorney
D 954.628.3526 | Wilkerson@LitchfieldCavo.com
FL | Ft. Lauderdale Office

June 2023

2023 Workers' Comp Law Update: 120-Day Denials and Denials of EMA

BACKGROUND

On May 31, 2023, the First District Court of Appeal established a time-sensitive burden on employers and insurance carriers that want to make use of the 120-day "pay and investigate" provision of the Workers' Compensation Statute 440.20(4). This is a procedural change in the law, in that it has retroactive applications to all workers' compensation cases currently in existence, not just future cases. Therefore, if there is an existing case where any benefits were provided *before* the claim was denied, it should be assigned to counsel for a critical legal review to determine if that denial can stand.

DETAILS

How to Avoid Waiving Goodbye to the 120 Day Denial

The workers' compensation system in Florida requires an Employer/Carrier (E/C) to act promptly in providing benefits to Claimants who require medical care and who are out of work as a result of a workplace accident. Benefits may only be withheld if a denial is entered. In context, these benefits are sometimes being provided before the E/C has a complete understanding of how the accident happened or what injuries are related to that accident. The E/C is clearly at a disadvantage under this scheme. Therefore, the law provides a remedy—the 120-day "pay-and-investigate" provision. This provision creates a right to investigate and delay the compensability determination up to 120 days after the first benefit was provided. This allows the E/C to assess the strength of a denial before exposing themselves to medical bills outside of fee schedule, penalties and interest on unpaid indemnity and possible litigation and attorney fees.

In the case of *Churchill v. DBI Services, LLC*, 2023 WL 3734607 (Fla. 1st. DCA May 31, 2023), Claimant suffered an accident and went to the emergency room, and was admitted to the hospital for five days. Upon release, Carrier authorized a primary care physician to continue to treat her for her injuries. Ten (10) days after her date of accident, Carrier paid for Claimant's first submitted benefit—prescription medications. Thirteen (13) days after her date of accident, Carrier commenced payment of temporary compensation benefits. Two months after the date of accident, Carrier sent a 120-day letter. As the 120-day deadline approached, Carrier denied the claim.

The First District Court of Appeal tells us that the E/C can only invoke this right to a delayed denial if a timely 120-day letter is sent to the claimant. But, what is "timely"? The Court held that a 120-day letter must be sent to the claimant "at the time of making the payment [of any benefit] or as soon thereafter as reasonably practicable." In *Churchill*, the Court found that payment of the prescription medication was the first benefit provided and that sending a 120-day letter 60 days after this payment was not timely. As such, the DCA said that the E/C waived the right to deny compensability. Ultimately, Churchill's case was sent back to the judge to establish compensability, award benefits and award attorney's fees.

In Practice

We glean from this case that it's imperative that carriers send the 120-day letters on the same day that any benefit payment (medical or indemnity) is issued. When in doubt about

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accepting compensability, send the letter to claimant. For example, if the carrier is issuing a benefit before the initial intake interview, best practice is to send the letter. Further, ensure that it contains appropriate language that tells the injured worker that it is unclear whether the accident is covered under workers' compensation and that the carrier has 120 days to make a decision. During that time, benefits will be paid and the carrier will provide another notice in writing if it decides to discontinue paying benefits.

Recent Legislature Distances Doctors From Courtrooms

On May 23, 2023, the Florida legislature enacted a change to the portion of the workers' compensation that deals with the appointment of an Expert Medical Advisor (EMA) statute. An EMA is allowed in workers' compensation cases when either a party or the judge identifies a "conflict" in medical opinions between two or more authorized physicians or Independent Medical Advisors (IME), which is a physician hired directly by a party. In such cases, the EMA acts as a neutral medical opinion, sometimes called a "judge's expert" because only the judge, not the parties, may have direct contact with this provider. The EMA's opinions are presumptively correct, as the Judge could only rule against the EMA in the face of "clear and convincing" evidence, which is a high burden to meet.

Previously, a Judge of Compensation Claims (JCC) was required to appoint an EMA any time a party made a timely request for one. However, the legislature *just* revised the statute to change the term "shall" to "may." As a result, the JCC now has discretion whether to appoint an EMA; it is no longer required. Said differently, the parties are not entitled to EMA review, even when a clear medical conflict exists.

Many questions remain as to how this will affect litigated claims going forward. First, this is considered a substantive change in the law, meaning it applies only to new cases, not old cases. However, there may be some challenges as to what is considered a "new" case. For example, there is a question of whether this newly established judicial discretion would apply to an accident that occurred before the statutory change even if no lawsuit was filed after the statutory change but the lawsuit wasn't filed until after. Second, will there be any uniformity amongst the judges as to when to grant or deny an EMA request? Are certain types of conflicts more or less likely to warrant resolution by a trained medical profession? For example, is it appropriate for a judge to impose their judgment when there is a conflict in the diagnosis? Or will the judges reserve their discretion to resolve conflicts in permanent impairment ratings which is subject to written guidelines?

Lastly, this statute change was likely enacted with the intent to benefit Employer/Carriers (after all, that is who bears the cost of EMAs), but it may not turn out that way. The legislature has effectively turned workers' comp litigation into the battle of the expert. As such, it is expected that claimant attorneys will start amping up their discovery to demonstrate bias in experts to damage their credibility. This is already very common in Florida's general liability arena. The process includes having an employee representative from the carrier testify as to how often a certain expert is retained and how much cumulatively is being paid to that expert.

Florida district courts have ruled that requiring carriers to disclose this information is permissible, as they are a party in litigation, but the same does not apply to claimant law firms, as they are not a party in litigation. Therefore, it is very likely there will be an increase in requests for production and depositions of adjusters and other representatives for the carrier to obtain this type of credibility-damaging information.

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In Practice

While the E/C has fewer avenues to discredit a claimant IME, the defense or the E/C need to get more creative in how to attack the credibility of a claimant IME opinion.

The most effective way is to demonstrate that a claimant provided factual information that is untrue. This approach is similar to a misrepresentation defense; however, the impact is much quicker and does not require proof that the omission or false statement was made with the intent to secure workers' compensation benefits. Instead, a motion to strike can be asserted, which would be argued in a pre-trial hearing. If successful, the opinion would then be stricken, and likely the case would not go to trial. A best approach? (1) through subpoena responses showing accurate past medical history; and, (2) through surveillance. The most cost-effective time for surveillance is the day of *and* the day before or after the claimant is set to attend an authorized medical appointment or E/C's IME appointment. If different behavior is exhibited to the doctor, it can then be argued that the doctor's opinions are not based upon reliable facts, which justifies the exclusion from evidence.

SUMMARY

Employer/carriers be warned—the 120-Day Letters must be sent when the first benefit is paid. Failure to do so is a waiver of every defense to compensability. Thus, only specific benefits may be disputed. However, medical disputes between doctors are no longer entitled to resolution by an Expert Medical Advisor.

David Gold's practice includes Florida workers' compensation and Federal Defense Base Act matters at both the trial and appellate levels. He has extensive experience defending all manner of cases–from routine injuries to the most complex matters involving permanent total disability. National retailers, airlines and numerous Fortune 500 companies have trusted David to defend their interests.

Lynne Wilkerson focuses on appellate practice and handles both civil and administrative appeals, extraordinary writs and motions work. She also defends employers and insurance carriers against workers' compensation claims.