HOW TO AVOID INADVERTENT ACCEPTANCE OF NON-COMPENSABLE CONDITIONS

HANDOUT

Presented by

R. Stephen Coonrod &

Suzanne Yong Gutierrez

HOW TO AVOID AND REMEDY INADVERTENT ACCEPTANCE OF NON-COMPENSABLE CONDITIONS

INTRODUCTION

The 2003 amendments to Florida's Workers Compensation Law sought to bring clarity to what types of conditions should be the responsibility of the Employer and their source of Workers Compensation coverage. The idea was to delineate what types of conditions would be covered through Workers Compensation and to ensure treatment and disability related to pre-existing and non-occupational conditions would not be. By creating specific compensability standards, a bright line could be created between what should be covered under Workers Compensation and what conditions should be the responsibility of the Employee. Everyone seemed to agree that Workers Compensation was not intended to replace a general health insurance policy.

STATUTORY PROVISIONS OF COMPENSABILITY

Section 440.09, Florida Statutes, provides clear standards for determining what conditions are compensable. The Employer/Carrier must pay benefits for accidental injuries or death arising out of work performed in the course and scope of employment. Specifically:

* The injury, its occupational cause and any resulting manifestations or disability must be established within a reasonable degree of medical certainty based on objective medical findings. The initial injury must be the Major Contributing Cause of any resulting injury.

* The establishment of the causal relationship between the accident and conditions which are not readily apparent must be established by medical evidence only. A traumatic accident such as an amputation or puncture wound does not require medical testimony in order to establish that an injury did occur. However, the existence of symptoms such as low back pain or discomfort in other parts of the body, cannot be considered work related unless there is medical testimony linking the symptoms and condition to the work activity.

* Injuries which combine with a pre-existing disease or conditions are compensable only to the extent the original injury is and remains the Major Contributing Cause of the condition which requires treatment and/or is disabling

* The Major Contributing Cause Standard is designed to prevent Workers Compensation from becoming responsible for a non-occupational or pre-existing condition, such as arthritis or other degenerative changes, even when those conditions involve the same body part where the compensable injury occurred.

If Section 440.09 operates as designed, the Employer/Carrier would never become responsible for non-occupational degenerative conditions, even though they involve the same body part as the compensable injury. For example, a knee strain, soft tissue or meniscal tear would be compensable if it was the result of trauma at work. However, underlying degenerative arthritis requiring a future knee replacement would not become the responsibility of Workers Compensation simply because it involves the same body part as the compensable injury.

HOW NON-COMPENSABLE INJURIES BECOME THE RESPONSIBILITY OF WORKERS COMPENSATION

Section 440.09, Florida Statutes, comprises but four pages of a Workers Compensation Statute that extends to almost 180 pages. Its nemesis in creating clarity as to compensable injuries is Section 440.20, Florida Statutes, which attempts to ensure timely provision of benefits and imposes consequences on those who do not comply with its terms. Nowhere in the payment provisions of Section 440.20, Florida Statutes, is a requirement that payment be made only for conditions that occurred at work. The term "Major Contributing Cause" is nowhere to be found in Section 440.20, Florida Statutes.

Section 440.20(2)(a) provides the Carrier must pay the first installment of compensation for total disability or death or deny compensability no later than the 14th calendar day after the Employer receives notification of the injury or death. Section 440.20(4), Florida Statutes, provides that if the Carrier is uncertain of its obligation to provide all benefits or compensation, the Carrier shall immediately and in good faith commence investigation of the Employee's entitlement to benefits. The Carrier shall admit or deny compensability within 120 days after the initial provision of compensation or benefits. Further:

* The Carrier shall provide written notice to the Employee that it has elected to pay the claim pending further investigation. The Carrier must advise the Employee of its decision within 120 days.

* A Carrier that fails to deny compensability within 120 days after the initial provision of benefits waives the right to deny the compensability unless the Carrier can establish material facts relevant to the issue of compensability that could not have been discovered through a reasonable investigation within the 120 days.

While Section 440.09, Florida Statutes, specifies what conditions are compensable, Section 440.20, Florida Statutes, provides that once an Employer begins paying for a condition, it has accepted that condition as compensable, potentially forever. Generally, the only exception is if the Carrier elects to pay-and-investigate and/or files a timely Denial.

Litigation involving the compensability of non-work related conditions almost always involves the conflict between Section 440.09 and Section 440.02, Florida Statutes. It should be noted that similar language is also contained in Section 440.192 which imposes identical obligations on the Employer/Carrier when responding to a Petition For Benefits.

WAIVING THE RIGHT TO DENY COMPENSABILITY

A Claimant need not present evidence that the compensable work accident is the Major Contributing Cause of a condition if the injury is compensable by operation of Law. Sierra v. Metropolitan Protective Services, 188 So.3d 863 (Fla. 1st DCA 2015). The Carrier that does not deny compensability of an injury within 120 days of the initial provision of benefits for that injury, waives the right to deny compensability of the injury. There is an exception to this Rule if the Carrier can establish material facts relevant to the issue of compensability that could not have been discovered through reasonable investigation. What constitutes "reasonable" is not defined in the Statute.

Once the Employer/Carrier has authorized treatment for the condition for more than 120 days, then it cannot deny further care for that condition unless it establishes a "break in the causal chain". This must be something more than simply providing proof that the compensable accident no longer remains the Major Contributing Cause of the need for treatment or that it was never the Major Contributing Cause in the first place.

ACCEPTANCE OF THE COMPENSAILITY OF A CONDITION

The actions or inactions of the Employer/Carrier can result in the acceptance of a condition as compensable.

The Employer/Carrier must clearly convey to the treating physician what specific conditions have been accepted as compensable. They must also monitor the medical care being provided and the bills which are submitted to ensure the treatment they are paying for is limited to the compensable conditions. As the Courts set out in the Sierra case, determining whether the Carrier has waived the right to deny compensability of an injury/condition requires the following findings:

1. The date the Employer/Carrier first provided benefits for the injury;

2. The identity of the specific injury for which benefits were provided; and

3. Whether the Employer/Carrier timely denied compensability of that injury within the 120 day period immediately following the initial provisions of benefits for that specific injury.

AUTHORIZATION OF TREATMENT FOR A CONDITION EQUALS ACCEPTANCE OF THAT CONDITION AS COMPENSABLE

The Carrier must monitor treatment being rendered by an authorized physician. If a non-compensable diagnosis is made, a Denial should be filed with the physician notifying him or her that treatment for that condition is not compensable. For example, "The Carrier has accepted an exacerbation of the pre-existing degenerative condition as compensable but has not accepted the underlying condition as compensable". Do not allow a situation to arise where, 120 days after treatment has commenced, authorization remains in place for general body parts such as "back" or "shoulder". The consequence of such general authorizations is that all back or shoulder conditions may be deemed compensable.

Remember that you and the Case Manager are the same. Authorization issues and medical treatment monitoring delegated to a Nurse Case Manager means you are responsible for what they do and fail to do.

Monitor the Diagnosis Codes which are being billed by the authorized physician. Payment of bills for a Diagnosis Code may be used as evidence that a particular diagnosis has been accepted as compensable. This can be of particular concern where payment of medical bills is delegated to a third party and is not monitored by the Adjuster who is most familiar with the claim.

Referrals to physical therapy and the physical therapy notes themselves contain references to what conditions are being treated. Those referrals and notes are evidence of what conditions have been accepted as compensable. Every time authorization is extended for treatment it presents an opportunity to specify, or fail to specify, what conditions have been accepted as compensable.

Diagnostic tests often provide the first notice that an individual suffers from degenerative and/or pre-existing conditions which may be relevant to the compensable injury. An Employee presents for care exhibiting symptoms and it is appropriate to authorize an evaluation, to include diagnostic tests, to determine the cause of those symptoms. However, when those tests reveal a pre-existing condition, such as degenerative joint disease, and/or degenerative disk disease, a Notice of Denial should be issued asserting that the Employee's conditions have not been accepted as compensable. A cervical sprain/strain and an exacerbation of the pre-existing condition can be accepted as compensable without an inadvertent acceptance of the underlying condition as compensable. If a cervical fusion is recommended several years later, the Employer/Carrier has preserved its ability to raise a Major Contributing Cause argument which will have been waived if authorization was merely extended for treatment of neck pain.

HOW TO REMEDY AN INADVERTANT ACCEPTANCE OF A CONDITION AS COMPENSABLE

In many cases it will be impossible to unaccept the compensability of a condition when care for that condition has been provided for more than 120 days. However, upon reviewing a file and realizing that the Claimant is receiving care for a non-compensable condition the following are potential solutions:

1. The Carrier establishes material facts relevant to the issue of compensability that it could not have discovered through reasonable investigation within the 120 day period.

The Statute contemplates that, if the Employer/Carrier chooses to pay and investigate a claim, then an investigation must actually take place. This would include obtaining a Statement from the Claimant as to his or her medical history and obtaining records from prior treating physicians. The First District Court Of Appeal has provided some guidance as to what constitutes a reasonable investigation. The requirement of an immediate and good faith investigation does not mandate that every investigative act that can be taken is, in fact, taken. It is merely a requirement that the Employer/Carrier be prepared to decide, within 120 days, what position they wish to take on a given claim and be accountable for that decision. Wintz v. Godwill, 898 So.2d 1089 (Fla. 1st DCA 2005). When the 120 day period begins to run is a factual determination. Sierra v. Metropolitan Protective Services, 188 So.3d 863 (Fla. 1st DCA 2015). In the case of Rente v. Orange County, 263 So.3d 294 (Fla. 1st DCA 2019), the Court noted that review of a physician's surgical notes should have brought to the Carrier's attention that a Claimant's personal condition pre-existed the industrial accident and, thereby alerting it to the necessity of beginning an investigation. The Carrier was presumed to have received the notes from the treating surgeon and was obligated to provide evidence that they had not. It was insufficient for the Carrier, who had already received notice of a pre-existing condition in the surgical report, to await the results of a conference with the physician before beginning the pay and investigate process. In essence, suspicion as to causation is what should prompt the investigation. The Rente case was remanded to the Judge of Compensation Claims to determine when the Employer/Carrier had material facts relevant to the issue of causation, whether the Carrier then immediately began the 120 day investigation and whether they denied compensability within 120 days thereafter.

MISREPRESENTATION

Misrepresentation by the Claimant are relevant not only to whether a reasonable investigation was timely conducted but also as to whether all benefits should be denied per Section 440.105 and Section 440.09(4), Florida Statutes. A successful Misrepresentation Defense results in a denial of all benefits regardless of how long benefits have been provided prior to that date. In the Rente decision, it was noted that the claimant had misrepresented his medical history to one of the treating physicians. While a Misrepresentation (Fraud) Defense

had not been asserted, the fact that the claimant had misrepresented his history was relevant to the question of how quickly the Employer/Carrier could effectively perform a reasonable investigation. Interestingly, the Court stated that a Misrepresentation along, in the absence of a Fraud Defense, is insufficient to establish that the Carrier had performed a timely investigation. It was but one relevant fact to be considered when evaluating when the Carrier was first put on notice of the pre-existing condition.

The Claimant who makes a false or misleading statement for the purposes of obtaining Workers Compensation benefits forfeits the entitlement to receive such benefits. In the case of Cal-Maine Foods v. Howard, 225 So.3d 898 (Fla. 1st DCA 2017), the Claimant sought medical treatment for an alleged incident at work one month after he was fired. During the initial doctor's visit he reported that the injuries to his head and neck occurred after he was hit with a baseball bat. The Claimant later stated that he misrepresented his history in order to obtain medical care because he believed it was too late to seek care for a work related injury. The Judge of Compensation Claims concluded that while Mr. Howard made a number of misrepresentations, she concluded the misrepresentations were irrelevant and/or not committed for the purposes of obtaining Workers Compensation benefits. The Judge of Compensation Claims had concluded that misrepresentations did not really occur if the medical doctors were later informed as to the true medical history. The District Court Of Appeal rejected this analysis and asserted that "honesty is not a luxury to be invoked at the convenience of a litigant". Further, "It should not be incumbent upon litigants to undertake exhaustive investigation to flush out the mendacities of an adversary. The parties have a right to expect that all statements, whether written or oral, are truthful and adequately responsive". The Court went on to note that the Claimant had been terminated based on a positive drug test for methamphetamine and amphetamine which was obtained after he drove a backhoe so far into the water that it had to be towed out.

The theme in the aforementioned cases seems to be there is little sympathy for an Employer/Carrier who passively provides benefits for an extended period of time and only later attempts to ascertain what conditions really are or are not work related. Another theme is that there is sympathy for the position of the Employer/Carrier when their investigation of the claim is thwarted by a Claimant's misrepresentations. One constant is that a diligent investigation is necessary if an Employee alleges the symptoms but the injury itself is not easily and objectively identified.

MEDICAL BENEFITS HANDOUT

Presented by

Caitlin Beyl & Christopher G. McCue

Medical Benefits

Presented by Caitlin Beyl & Christopher G. McCue

I. Compensability of Medical Benefits

A. Compensable Care is Limited to that which is Medically Necessary.

1. §440.09, Florida Statutes
   a. Established to a reasonable degree of medical certainty;
   b. Based on objective relevant medial findings;
      i. §444.09(1), definition
         - Objective relevant medial findings are those objective findings that correlate to the subjective complaints of the injured employee and are confirmed by physical examination findings or diagnostic testing.
      ii. Pain or subjective complaints alone are not compensable.
   c. Accidental compensable injury must be the major contributing cause of the need for treatment.
      i. §440.9(1), definition
         - Major contributing cause means the cause which is more than 50 percent responsible for the injury as compared to all other causes combined for which treatment or benefits are sought.
      ii. Premier Community Healthcare Group v. Rivera, 282 So. 3d 1020, 1020 (Fla. 1st DCA 2019). Claimants have the burden of proving a workplace injury is the major contributing cause of the need for medical care by providing competent substantial evidence. When a claimant has a preexisting injury, an employer/carrier ("E/C") is responsible only to the extent that the workplace injury arose out of the course and scope of employment and the injury remains more than 50 percent responsible for the injury.
      iii. Only medical evidence through admissible medical opinions can prove major contributing cause, §440.13(5)(e).
2. Consent to medical necessity
   a. §440.13(3)(d)
      - A carrier must respond by telephone or in writing to a request for authorization from an authorized care provider by the close of the 3rd business day after receipt of the request. A carrier who fails to respond to a written request for authorization for referral for medical treatment by the close of the 3rd business day after receipt of the request consents to the medical necessity for such treatment. All such requests must be made to the carrier. Notice to the carrier does not include notice to the employer.
   b. 3 business days vs. 10 business days
      i. City of Panama City and PGCS v. Bagshaw, 65 So. 3d 614 (Fla. 1st DCA 2011). Workers' compensation statutes requiring an E/C to respond to a request for

authorization within three days, or within ten days if the request is for certain specialty care, do not require an E/C to authorize a referral request by an authorized treating doctor within the time specified, but they do require an E/C to respond. Even if an E/C waives its right to question the medical need for requested treatment, by failing to timely respond to the request, it may yet content that the workers' compensation claimant's compensable injury is not the reason treatment is needed.

ii. Elmer v. Southland Corporation, 5 So. 3d 754 (Fla. 1st DCA 2009). E/C was estopped from arguing that referral to a pain management specialist was not reasonably and medically necessary, where E/C failed to respond to repeated written requests by claimant's authorized treating physician for such a referral. This court has held that section 440.13(3)(d) must be read in pari materia with sections 440.13(2)(a), and (c). See St. Augustine Marine Canvas & Upholstery, Inc. v. Lunsford, 917 So. 2d 280,284 (Fla. 1st DCA 2005) (holding these sections are properly read together). The latter two statutes provide a caveat that any medical care provided under section 440.13 must be medically necessary as a result of a compensable injury. Applying section 440.13(2)(a), an E/C that fails to timely respond to a referral request is only required to continue providing the recommended treatment so long as it is reasonably and medically necessary. See Province Prop. & Cas v. Wilson, 990 So .2d 1224 (Fla. 1st DCA 2008); Dawson v. Clerk of the Cir. Ct. –Hillsborough County, 991 So. 2d 407 (Fla. 1st DCA 2008) (holding change of physician pursuant to section 440.13(2)(f) regardless of E/C's opinion as to the medical necessity of further treatment, an E/C is only obligated to provide treatment recommended by the new doctor that is reasonably and medically necessary).

iii. Pearson v. BH Transfer, 163 So. 3d 1270 (Fla. 1st DCA 2015). Workers' compensation carrier failed to timely respond to claimant's request for spinal surgery that was recommended by claimant's treating physician, and, thus, carrier forfeited the right to contest whether the referral was reasonable and medically necessary.

3. §440.13
   a. Definition
   b. Determined by substance of evidence, Trejo v. Arry's Roofing, 141 So .3d 220 (Fla. 1st DCA 2014). The Judge of Compensation Claim's determination of reasonably medical certainty depends on the substance of evidence rather than the use of reasonable medical certainty terminology, or any other so-called "magic words," by a medical witness. Unrebutted medical testimony, in workers' compensation case, can be rejected, so long as there is a reasonable evidentiary basis for doing so.

B. Compensable Care Must be based on Admissible Medical Opinions
   1. Authorized Health Care Provider.
      a. Only testimony of an expert medical advisor, an independent medical examiner, or an authorized treating physician is admissible at a hearing before the judge of compensation claims ("JCC"). St. Augustine Marine Canvas & Upholstery, Inc. v. Lunsford, 917 So. 2d 389 (Fla. 1st DCA 2005).

2. Independent Medical Examiner
   a. §440.12(5), Florida Statutes
      - Permits an independent medical examination ("IME") when there is a dispute concerning overutilization, medical benefits, compensability, or disability.
   b. The only condition required for a party to request an IME in a workers' compensation case is a dispute. Stahl v. Hialeah Hospital, 127 So. 3d 1283 (Fla. 1st DCA 2013). This case also provides the statute governing use of IMEs in workers' compensation cases permits one independent medical examiner per accident to conduct multiple IMEs as the need for such arises with various different disputes. However, §440.12(2)(d) does not grant an E/C an independent right to an IME whenever the E/C suspects a claimant is not adequately progressing. Bellamy v. Golden Flake Snack Foods, Inc., 97 So. 3d 941 (Fla. 1st DCA 2010). Rather, this section presumes the existence of a dispute warranting the initial appointment of an IME. The E/C has the burden to prove denial of a medical benefit, thereby creating a dispute among the parties to warrant presentation of an IME.
   c. Workers' compensation statute, governing medical services, allows for one independent medical examiner per accident, and not one per specialty. Gomer v. Ridenhour Concrete & Supply, 42 So. 3d 855 (Fla. 1st DCA 2011). Each party is entitled to an IME for each covered dispute during the life of a claim, so long as it is performed by the same examiner. An alternative examiner is allowed only if the following three criteria are met:
      i. The examiner selected is not qualified to render an opinion upon an aspect of the employee's illness or injury which is material to the claim or petition for benefits;
      ii. The examiner ceases to practice in the specialty relevant to the employee's conditions;
      iii. The parties agree to an alternative examiner.
   d. An IME cannot be one of the claimant's treating physicians, nor can an IME provide follow up care, even if the care is medically necessary, per section 440.13(5)(a), Florida Statutes.
3. Expert Medical Advisor
   a. §440.12(9), conflict in medical opinions
   b. Nearly conclusive effect, Taylor v. TGI Friday's, Inc., 108 So. 3d 698 (Fla. 1st DCA 2013). The opinion of an expert medical advisor ("EMA") is presumed correct unless there is clear and convincing evidence to the contrary as determined by the JCC. Arnau v. Winn-Dixie Stores, 105 So. 3d 669 (Fla. 1st DCA 2013). Moreover, this Court held that an EMA's opinion should be given even greater deference when the recommendation is in favor or a diagnostic evaluation because the court has repeatedly held that diagnostic testing and evaluations are always compensable if the purpose is to find out the cause of the claimant's symptoms.
   c. Admissibility of EMA opinion, Lowe's Home Center and Sedgwick CMS v. Beekman, 187 So. 3d 318 (Fla. 1st DCA 2016). Those opinions voiced by an EMA selected by the JCC to help resolve a conflict in the medical evidence in a workers' compensation proceeding, which "exceed the scope" of the perceived disagreement, would be admissible, but not presumptively correct; therefore, the opinions intended

to carry the presumption of correctness are only those that address already identified disagreements in medical opinions, with all other medical opinions expressed by the EMA carrying the same weight as that of an independent medical examiner or an authorized treating physician.

d. De Jesus Abreu v. Riverland Elementary School, 2019 WL 2505304 (Fla. 1st DCA 2019). The presumed correctness of an EMA is not an irrebuttable presumption and, thus, does not violate a claimant's right to due process or equal protection, nor is it a violation of the separation of powers.
e. When to request an EMA/Timeliness
    i. Gary Steinberg v. City of Tallahassee, 186 So. 3d 61 (Fla. 1st DCA 2016). Even though the statutory duty of a JCC to appoint an EMA in proper circumstances is mandatory, a JCC's failure to sua sponte appoint an EMA is not a fundamental error and, thus, such error must be preserved for review in workers' compensation cases. Purpose of a request for an EMA in a workers' compensation case is not to give the opposing litigant notice, but to inform the JCC of her mandatory duty early enough not to disrupt orderly proceedings.
    ii. Quiroga v. First Baptist Church at Weston, 124 So. 3d 936 (Fla. 1st DCA 2013). Although a JCC is required to appoint an EMA where there is a disagreement in medical opinions, a party who does not timely seek the appointment of an EMA below will not be heard on appeal to complain of the failure to designate an EMA in a workers' compensation case.
    iii. "Unreasonably delayed," Palm Springs General Hospital v. Cabrera, 698 So. 2d 1352 (Fla. 1st DCA 1997). In workers' compensation proceeding, party who has complied fully with all pretrial orders should not be foreclosed from requesting evaluation by EMA, if request is made with reasonable promptness once conflict in health care providers' opinions surfaces. Requirements of statute, providing for appointment of EMA in workers' compensation proceeding when health care providers disagree, are mandatory and binding on JCC.
    iv. "Reasonable promptness," AT&T Wireless v. Frazier, 871 So. 2d 939 (Fla. 1st DCA 2004). JCC was required to grant request of E/C for appointment of an EMA, even though appointment of EMA would necessitate continuing scheduled merit hearing, where request for appointment of EMA was made with reasonable promptness after E/C discovered conflict in opinions of treating physician and physician who performed IME of claimant, and statutory time limits for holding of merits hearing were directory, rather than mandatory. Time limitations contained in workers' compensation statute on procedures for mediation and hearing are directory, not mandatory, and they do not foreclose appointment of EMA when request is made with reasonable promptness after conflict in medical opinions becomes apparent.
    v. Baycare Home Center Medical Supply v. Santiago, 220 So. 3d 1286 (Fla. 1st DCA 2017). Where a conflict exists and an EMA is appointed, where report is clear but deposition testimony of doctor is not, the JCC still must articulate clear and convincing evidence to reject the opinion, unlike those situations where EMA is not involved.

vi. Know your jurisdiction: know how various JCCs are interpreting these cases.

II. What Benefits are Compensable

A. Chiropractic Care

1. Date of accident dictate the amount of chiropractic care
    a. Section 440.13(2)(a), Florida Statutes, which limits chiropractic treatment, is substantive in nature and cannot be applied retroactively. Russel v. P.I.E. Nationwide & Alexis, Inc., 668 So. 2d 696 (Fla.1std DCA 1996).
    b. Workers' compensation law limits the amount of chiropractic treatment that can be authorized for most claimants whose date of accident is after 12/31/1993 but before 10/01/2003. Pursuant to the 1994 through 2002 versions of §440.13(2)(a), Florida Statutes: "Medically necessary treatment, care, and attendance does not include chiropractic services in excess of 18 treatments or rendered 8 weeks beyond the date of initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the employee is catastrophically injured."
    c. Workers' compensation law continues to limit chiropractic treatment for most claimants whose date of accident is after 10/01/2003 and does so using the following language of §440.13(2)(a): "Medically necessary treatment, care, and attendance does not include chiropractic services in excess of 24 treatments or rendered 12 weeks beyond the date of initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the employees is catastrophically injured." Note that, under both versions, the caps may be avoided either by the carrier's choice of additional authorization or the claimant's proof of catastrophic injury.
2. Limit on care does not violate constitutional rights. Strohm v. The Hertz Corporation, 685 So. 2d 37 (Fla. 1st DCA 1996). Workers' compensation statute providing that medically necessary treatment does not include chiropractic services in excess of 18 treatments denies neither equal protection nor due process; statute does not deny a fair hearing or erect any classification scheme that fails to bear reasonable relationship to legitimate state interest.

B. Massage Therapy

1. Accurate Reporters v. Moore, 605 So. 2d 585 (Fla. 1st DCA 1992). Award of massage therapy was supported by competent substantial evidence, including testimony of chiropractor.

C. Attendant Care

1. Claimant's burden, Orange County Sheriff's Department v. Perez, 541So. 2d 652 (Fla. 1st DCA 1989). It is burden of claimant for attendant care to prove quantity, quality, and duration of attendant services claimed.
2. Attendant care services defined
    a. AT&T Wireless Services, Inc. v. Castro, 896 So. 2d 828 (Fla. 1st DCA 2005). Not all attendant care services are compensable under workers' compensation law. Normally, only direct attendant care that is medically necessary is compensable under workers' compensation law, and generally, attendant care considered medically

necessary includes only bathing, dressing, administering medication, and assisting with sanitary functions.

b. Palm Beach County School Board v. Zabik, 906 So. 2d 362 (Fla. 1st DCA 2005). Workers' compensation statute permitting award for "attendant care" services did not encompass award of two hours of attendant care a week for assistance in carrying groceries and laundry up three flights of stairs to claimant's apartment; statute did not provide special blanket exception, to ordinary "household duties" rule, for claimants who live alone and do not have family members or friends available to provide dependable, convenient assistance with domestic chores when needed.

c. Broadspire v. Jones, 164 So. 3d 708 (Fla. 1st DCA 2015). Ordinarily household duties, such as shopping and cooking, are gratuitous in nature and not compensable attendant care. Only extraordinary services by family members, such as assistance with bathing, dressing, administering medication, and sanitary functions, may be considered compensable attendant care in a workers' compensation case. In deciding whether to award claimant attendant care from his wife, the JCC was required to make specific factual findings and conclusions of law as to whether care provided by wife was compensable as extraordinary services or awardable "on-call" attendant care, where some services provided by wife were non-compensable ordinary household duties and quality-of-life activities. In limited circumstances, household services may be compensable attendant care if the caretaker of a claimant substantially departs from his or her daily routine to provide care, or if the claimant is completely prevented from doing such activities on his or her own.

d. Sufficient disagreement in opinions of health care provider, Altemar v. Lifespace Communities, Inc., 249 So. 3d 1319 (Fla. 1st DCA 2018). The JCC improperly presumed the of correctness an EMA's testimony when regarding the medical necessity for attendant care where claimant's IME rendered no definitive opinion on claimant's need for attendant care.

3. Prescriptions for attendant care

a. Dade County School Board v. Grier, 648 So. 2d 805 (Fla. 1st DCA 1994). Competent, substantial evidence supported award of attendant care benefits during claimant's "crisis periods," but no competent, substantial evidence supported award of attendant care during non-crisis periods; majority of tasks performed by claimant's daughters, i.e., cooking and cleaning, were not those going beyond scope of duties performed gratuitously by family member, and other tasks performed by daughters, although extraordinary in nature, were not compensable because doctor did not testify that claimant needed assistance with such tasks; tasks performed by claimant's boyfriend such as administering medication were of a type normally compensable as attendant care, but doctor again did not specify that claimant required assistance for such tasks; moreover, boyfriend's driving claimant to her mother's home and driving claimant's daughters to the store were not compensable under the statute.

b. Windham Builders, Inc. v. Overloop, 951 So. 2d 40 (Fla. 1st DCA 2007). An E/C may not avoid payment by willful ignorance. An E/C must monitor a claimant's injuries and provided needed benefits. Substantial evidence supported trial court's

factual finding that workers' compensation claimant's failure to provide a written prescription for attendant care following surgery for an ankle injury was the result of willful ignorance of the part of the E/C, and thus E/C would be required to pay for such attendant care despite the lack of a written prescription; E/C communicated with claimant's physician regarding billing information without informing him of the requirement for a written prescription, and had many conversations with claimant's wife, who provided the care pursuant to an oral prescription, without informing her of the requirement.

4. Self-executing, IMC Phosphates Co. v. Prater, 895 So. 2d 1263 (Fla. 1st DCA 2005). Physician's failure to expressly prescribe attendant care is not determinative of workers' compensation claimant's right to recover such benefits; it is sufficient that the physician provided the necessary testimony at the hearing per §440.13, Florida Statutes. The self-executing nature of workers' compensation law requires an E/C to monitor a claimant's injuries, procedures, and progress, and to provide needed benefits.
5. Valuation of professional and non-professionals.
    a. §440.13(2)(b), depends on employment
    b. Bonnie Scott v. Sears Holdings, 189 So. 3d 1035 (Fla. 1st DCA 2016). Section 440.13(3)(b), Florida Statutes, which limits payments of nonprofessional attendant care by family members to the federal minimum hourly wage, was found to be constitutional.

D. Diagnostics
    1. Rule in/out compensability, Sanchez v. Security Sales Co., 522 So. 2d 435 (Fla. 1st DCA 1988). Whenever the purpose of the diagnostic test is to determine the cause of claimant's symptoms, which symptoms may be related to a compensable accident, the cost of the diagnostic test is compensable.
    2. Purpose of diagnostic test, Martinez v. Association of Poinciana, 642 So. 2d 118 (Fla. 1st DCA 1994). Purpose for which diagnostic testing and evaluation of workers' compensable claimant are undertaken, rather than results thereof, determines the compensability of such services.
    3. Claimant carries burden of proof, Alvarez v. Ft. Pierce Police Department, 186 So. 3d 582 (Fla. 1st DCA 2016). Diagnostic testing is always a compensable workers' compensation expense if the purpose is to find out the cause of an injured worker's symptoms; this is true even if the tests prove the symptoms are unrelated to the compensable injury.

E. Self-help
    1. Elements of self-help, Parodi v. Florida Contracting Co. Inc., 16 So. 3d 958 (Fla. 1st DCA 2009). An employer's right to select and/or authorized doctors from whom an employee may receive treatment is concomitant with it affirmative duty to provide appropriate care at the appropriate time; thus, so long as employer fulfills its duty, it retains the right to select and authorize physicians to treat the injured worker. When an employer abandons its obligation to provide appropriate care to an injured employee, it likewise surrenders to the injured employee the right to select a physician and obtain treatment, provided the care is compensable. Also see, Sears Outlet v. Brown, 152 So. 3d 785, 787 (Fla. 1st DCA 2014), finding the self-help provision did not apply because

claimant did not make a specific request for authorization and the condition for which he obtained care was not likely related to the compensable injury.

2. Admissibility of medical opinions of self-help doctor, Hidden v. Day & Zimmerman, 202 So. 3d 441 (Fla. 1st DCA 2016). The medical opinions of an unauthorized self-help doctor are not admissible in workers' compensation proceedings unless and until it is established by other admissible evidence and medical opinions that the care rendered by self-help doctor was compensable and medically necessary.

F. Remedial and palliative care
   1. §440.13(13)
   2. Mitigation of condition, Clements v. Morrow's Nut House, 598 So. 2d 279 (Fla. 1st DCA 1992). E/C's obligation to provide "medically necessary" remedial treatment and care extends to provision of palliative treatment mitigating condition or effects of injury. Testimony by physiatrist that chiropractic care received by claimant had not afforded claimant a "progressive and sustained benefit" did not establish that such care was not "medically reasonable and necessary" pursuant to statute, and did not provide basis for denying claim for past and future chiropractic care.
   3. Use of prescribed medical devise or apparatus can constitute remedial treatment, Gore v. Lee County School Board, 43 So. 3d 846 (Fla. 1st DCA 2010). A workers' compensation claimant's use of prescribed medical devise or apparatus, with the knowledge of the E/C, constitutes "remedial treatment" furnished by E/C that tolls the statute of limitations on filing of a petition for benefits. But see Ring Power Corporation v. Murphy, 238 So.3d 906 (Fla. 1st DCA 2018), holding the statute of limitations is not tolled indefinitely for claimant who had rods and screws set in place on her spine after spinal fusion surgery. The rods and screws only furnished remedial care for a temporary purpose and tolled the statute of limitations only for the amount of time they served that purpose.

G. Hindrance to recovery doctrine: Unrelated Conditions
   1. Brevard County School Board v. Acosta, 141 So. 3d 233 (Fla. 1st DCA 2014). Under the hindrance-to-recovery doctrine, it is the purpose of the treatment that determines workers' compensation compensability. Under workers' compensation law, employer was not responsible for medical treatment required independently by non-compensable left shoulder injury if the removal of hindrance was only incidental to the recovery of the compensable right shoulder injury.
   2. Mellon Security & Sound v. Custer, 687 So. 2d 1372 (Fla. 1st DCA 1997). An E/C was responsible for providing claimant with treatment for preexisting conditions of obesity and hypertension, where treating physician agreed that treatment of those conditions was medically necessary to claimant's treatment and recovery from compensable injuries to claimant's neck and back.
   3. Federal Express Corp. v. Lupo, 77 So. 3d 899 (2012). An E/C is not responsible for providing treatment for a preexisting condition when the aggravation of the preexisting condition is not the major contributing cause for the need for treatment.
   4. Tyson v. Palm Beach County School Board, 913 So. 2d 105 (Fla. 1st DCA 2005). The "hindrance to recovery theory" for workers' compensation benefits makes treatment or assistance compensable only to the extent treatment or assistance is necessary for

compensable injuries, not generally to keep a claimant healthy and safe. A claimant who was receiving attendant care benefits in the amount of 17 hours per week as a result of her compensable conditions at time she was involved in motor vehicle accident that caused her to need 24-hour a day attendant care, was entitled to attendant care benefits for time spent assisting claimant with the administration of medicines related to her compensable conditions; such assistance would not be required if not for the compensable conditions.

H. Trigger Theory
   1. City of Jacksonville v. O'Neal, WL 3042015, June 8, 2020 (opinion not yet released and subject to revision or withdrawal) E/C appealed a final compensation order entered in favor of Claimant who suffered from a cardiac injury. The court provided that the trigger theory applies if an E/C can prove there is an underlying condition, or so called "trigger" resulting in heart disease. After E/C proves there is an underlying condition, the trigger theory requires an E/C to overcome: (1) the statutory presumption of the underlying condition and (2) the statutory presumption of the condition's triggering event. The parties stipulated Claimant was diagnosed with atrial tachycardia that degenerated to atrial fibrillation. Medical testimony revealed that while job stress could play a role in causing arrhythmia, job stress could not be implicated in the development of atrial fibrillation. Based on the medical evidence, Claimant's peak exercise workouts triggered degeneration of his heart condition to atrial fibrillation. The court reversed and remanded for further consideration as this medical evidence was not evaluated as a non-occupational cause in the JCC's trigger theory analysis.

III. Strategies for Maintaining Control of Medical Benefits

A. Maintain Right of Selection of Health Care Provider
   1. §440.09(1) and §440.13(2)

B. One Time Change
   1. 5 days
      a. Gadol v. Masoret Yehudit, Inc./U.S. Adm'r Claims, 132 So. 3d 939 (Fla. 1st DCA 2014). The five-day response period in workers' compensation statute authorizing a one-time change of physician within 5 days after receipt of the claimant's written request, refers to calendar days, not business days. An E/C timely responds to a claimant's written request for a one-time change, as required by statute authorizing such a one-time change, by informing the claimant of the new doctor's name; a timely response does not require the E/C to actually contact or schedule an appointment with the new doctor.
      b. Renewal of 5 days when initial doctor declines to treat, Jackson v. City of Pompano Beach/Corvel Corp., 14-020882MRH, August 7, 2013.
   2. Required Notice
      a. Bustamante v. Amber Constructions, Co., 118 So. 3d 921 (Fla. 1st DCA 2013). Unilateral notice to health care provider by E/C that it had authorized claimant to be seen by a particular health care provider failed to comply with claimant's one-time change request for change of physician within mandatory 5 day time period, and, thus claimant was entitled to select his own physician.

b. City of Bartow v. Flores, 2020 WL2781872, May 29, 2020. E/C forfeits its right of selection when it fails to provide the alternate physician by unreasonable delay in acquisition of the appointment date. E/C has a two-fold obligation in this regard: (1) timely authorization and (2) provision of the physician by acquiring an appointment date and informing the Claimant of the appointment. Per §440.13, the word "provision" means "actual provision" or actually setting an appointment, not merely authorization. The court certified the question of whether an E/C's duty is fulfilled solely by timely authorization.

3. Right to One Time Change is Absolute
    a. Dominguez v. Compass Group, 219 So. 3d 223 (Fla. 1st DCA 2017). A Claimant's right to a one time change of treating physician is absolute if the request is made during the course of treatment.
    b. Krysiak v. City of Kissimmee, 289 So. 3d 948 (Fla. 1st DCA 2020). Claimant waived his right to the one-time change and contradicted his objection when he acquiesced to E/C's selection by attending the appointments with E/C's authorized physician.
4. A One Time Change Must be in the Same Specialty
    a. RetailFirst v. Davis, 207 So. 3d 1035 (Fla. 1st DCA 2017); Zekanovic v. American II, Corp., 208 So.3d 851 (Fla. 1st DCA 2017). The change must be in the same specialty regardless of who makes the selection.

C. Distance for Travel
1. Offering transportation, Carrol v. Florida Office Supply/Amerisure, 09-002073MES, April 2016. Judge Sojourner held that offering transportation does not lessen the travel time involved for 4 hours of round trip travel and 239 miles round trip is unreasonable.
2. Reasonableness
    a. Miller v. Jupiter Medical Center, 928 So. 2d 485 (Fla. 1st DCA 2060). Workers' compensation claimant filed petition for writ of certiorari seeking review of an order of the JCC compelling claimant to undergo an IME with a different physician than the physician who performed a prior IME, who was outside of claimant's county of residence. There is no limitation in section 440.13(5) regarding the geographical location of an IME. This court has repeatedly stated that there is simply a "reasonableness" requirement in the IME provisions that is subject to a JCC's exercise of discretion.
    b. Florida Administrative Code, Rule 59A-23.003(6), provides information which indicates the ability of the insurer or delegate entity to provide geographic access to health services for injured employees. Average travel time for injured employees from the employee's usual employment site to the nearest primary are delivery site and to the nearest general acute care hospital in the provider network shall be no longer than 30 minutes under normal circumstances. Average travel time from the employee's usual employment site to the nearest provider of specialty physician service, ancillary services, specialty inpatient hospital services and all other health services shall be no longer than 60 minutes under normal circumstances.

c. Jennifer Meilke v. R & L Carriers/CCMSI, 15-010535 MRH, November 2015. Claimant sought a protective order preventing E/C from authorizing a pain management evaluation in Orlando, which would require claimant to travel approximately two hours from her home and/or place of employment. The E/C asserted claimant lives and works in a geographically remote area, and travel to Gainesville would also require approximately two hours of travel time. However, claimant testified several pain management physicians are located in The Villages, approximately 15 minutes from claimant's home. The court considered Florida Administrative Code Rule 59A-23.003(6) and found it unreasonable for the E/C to require claimant to travel approximately two hours for a pain management evaluation. This is especially true when several pain management physicians are located within 15 minutes of Claimant's home. Judge Hill granted claimant's Motion for Protective Order and held the E/C shall authorize a pain management evaluation with a pain management physician located within 30 minutes of Claimant's home.

D. Statute of Limitations
   1. City of Dania Beach v. Zipoli, 204 So. 3d 52 (Fla. 1st DCA 2016). A petition for benefits must be filed within two years after the date a claimant knew or should have known that his injury arose out of a compensable, work-related event, with the exception that the two-year period is tolled for one year following the date any indemnity benefit is paid or medical treatment is furnished.

E. Surveillance
   1. Dieujuste v. J, Dodd Plumbing, Inc.3 So. 3d 1275 (Fla. 1sr DCA 2009). Activities observable on surveillance video can serve as a basis for finding of misrepresentation as to a claimant's physical abilities, however, only oral or written statements can serve as the predicate for disqualification from benefits. Evidence in workers' compensation proceedings did not support finding of the JCC that claimant had misrepresented his physical condition, so as to warrant disqualifying claimant from receiving benefits for a compensable knee injury, even though surveillance video showed claimant, who brought a cane or crutch to his doctor visits, walking short distances without assistance; nothing on surveillance video or in the medical evidence was inconsistent with any oral or written statement made by claimant, who admitted that he could walk without assistance but alleged that he had problems putting weight on knee and that he experienced severe pain.
   2. Must comply with rules of discovery if offering into evidence, Holiday Inn v. Re, 643 So. 2d 13 (Fla. 1st DCA 1994). Failure of E/C to tender production of surveillance videotape to claimant until more than five months after the request was made violated rules of discovery, and thus exclusion of surveillance evidence was appropriate.

IV. Medical Bills and Pharmaceuticals

A. Medical Bills
   1. Sansone v. Crum, 201 So. 3d 1289 (Fla. 1st DCA 2016). When it comes to medical benefits, a workers' compensation claimant's successful prosecution ends when the E/C accepts responsibility, regardless of when the E/C actually pays the medical providers, for purposes

of statute providing the attorney fees require the successful prosecution of the petition, but fees cannot attach until 30 days after the employer receives the petition.

2. Morgan v. American Airlines, WL 2544433, May 19, 2020. Claimant failed to demonstrate successful prosecution – i.e. her attorney's efforts did not achieve acceptance and payment of claim – when E/C never denied the claim. The JCC made no relevant findings on Claimant's entitlement to costs and Claimant failed to timely bring this oversight to the attention of the JCC on motion for rehearing. The court held the issue of entitlement to costs was not preserved for appellate review.

B. Guides for Maximum Reimbursement Allowances, §440.13 (12)(c)

1. Reimbursement for Prescription Medications – the reimbursement amount for a prescription shall be the average wholesale price plus $4.18 for the dispensing fee.
2. Reimbursement for Physician Dispensed Medications – for repackaged or relabeled prescription medications dispensed by a dispensing practitioner, the fee schedule for reimbursement shall be 112.5 percent of the average wholesale price, plus $8.00 for the dispensing fee.
    a. Carriers can limit physician's ability to dispense.