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Medicare Compliance Alert

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Become Fee Driven in Florida?**

**The Changing Faces of Indemnity
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Release of All Claims: Mutual Mistake

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Trevor Hawes**

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MEET ONE OF OUR LAWYERS

Trevor Hawes



Trevor Hawes is a partner in the firm's Jacksonville office. He has a civil trial practice that encompasses commercial litigation, insurance coverage matters, and liability defense. He represents banks, real estate brokers and agents, insurance carriers and insureds, architects and developers, product manufacturers and distributors, self-insured businesses and individuals. Mr. Hawes has maintained his focus in the above areas since starting his professional career. Mr. Hawes' practice is statewide and he has appeared in numerous jurisdictions in Florida.

Mr. Hawes completed his undergraduate studies at Florida State University in 1997. He attended law school at Nova Southeastern University and obtained his juris doctorate in 2001. Mr. Hawes was admitted to the Florida Bar in 2001.

Mr. Hawes is admitted to practice in all jurisdictions in the state court system for the State of Florida. He is also admitted and regularly practices in all of the federal court jurisdictions and bankruptcy courts in the State. He is also admitted to practice before the 11th Circuit Court of Appeals. Additionally, Mr. Hawes is an active member of the Florida and Jacksonville Bar Associations.



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MEDICARE COMPLIANCE ALERT

*What Liability Insurers, No-Fault Insurers, Self-Insurers And Workers' Compensation Carriers
Need To Know About The Medicare Secondary Payer Statute's Reporting Requirements*



By Alejandro Perez

On July 1, 2009, the Medicare Secondary Payer Act (the "MSPA") will impose new and *mandatory* reporting requirements on all workers' compensation carriers and liability, no-fault and self-insurers ("primary payers").¹ Failure to comply with the MSPA's new reporting requirements *will* result in crippling fines. The Center for Medicare & Medicaid Services ("CMS") has provided limited guidance on how to comply with the MSPA's reporting requirements. These reporting requirements will have an immediate impact on primary payers, who must adjust their claims handling protocols to make certain that all of the information required by CMS is properly collected and reported. This article will summarize and provide preliminary suggestions on how to comply with these new requirements.²

How Has The Medicare Secondary Payer Act Been Applied In The Workers' Compensation Context?

CMS has not yet clarified what procedures it will establish to facilitate the protection of Medicare's future interests in general liability matters. Thus, it may be instructive to review what protocols CMS has implemented in the workers' compensation context.

In 2001, CMS directed parties to establish Trust accounts to fund the future medical costs of workers' compensation claimants.³ These trusts are better known as Medicare Set Aside Trusts ("MSA Trusts").⁴ To establish a MSA Trust, a workers' compensation carrier must estimate the costs funding a claimant's future medical expenses, determine whether to fund the MSA Trust via a lump sum payment or structured annuity arrangement, and determine whether to administer the MSA Trust through a third party or via self-administration.⁵ The goal is to utilize the MSA Trust solely to pay for future covered medical expenses.

Through subsequent administrative memoranda, CMS established a MSA Trust review thresholds for workers' compensation cases. These thresholds provide that a formal MSA Trust should be prepared when (1) a claimant is a Medicare beneficiary at the time of settlement and the total settlement amount⁶ exceeds \$25,000, and (2) the claimant has a reasonable expectation⁷ of Medicare eligibility within 30 months and the total settlement amount is greater than \$250,000.00.⁸ While these thresholds do not specifically apply to primary payers, CMS' utilization of these thresholds in

workers' compensation cases suggests that these thresholds, or at least a similar approach, may be utilized when dealing with primary payers.

While the above thresholds are not required beyond the workers' compensation context at the moment, we expect that CMS will likely implement similar threshold procedures to assist primary payers in determining when and whether a MSA Trust would be appropriate.

What Is The Medicare Secondary Payer Act And Why Do Primary Payers Need To Know About It?

One of the common covered costs assumed by primary payers is for medical expenses. Whenever an insured has Medicare, both the primary payer and Medicare have an obligation to cover these services. The MSPA makes Medicare the secondary payer for medical services provided to Medicare beneficiaries whenever payment is available from another primary payer.⁹ Thus, whenever a primary payer is responsible for payment of medical services covered by Medicare, it must pay these costs first, or otherwise reimburse Medicare for conditional payments made prior to resolution of the claim.¹⁰ Of course, whether a primary payer intends to pay a claim usually requires investigation. In these cases, Medicare is authorized to make "conditional payments" for covered medical services if the primary payer is not expected to pay within 120 days.¹¹ Failure to pay or reimburse Medicare can expose primary payers to liability to the federal government for repayment of costs incurred by Medicare and double damages if an individual commences suit.¹²

Starting on July 1, 2009, primary payers must (1) "determine whether a claimant ... is entitled to benefits," even if the claim is unresolved; and (2) report an extensive amount of data to CMS about these claimants in order to permit CMS to coordinate benefits.¹³ Failure to comply with these mandatory



reporting requirements will result in penalties of \$1,000.00 per day, per claim, for non-compliance.¹⁴ In light of these potentially crippling fines, the question faced by all primary payers is what steps should be taken to comply with the MSPA's reporting requirements and avoid any financial penalties.¹⁵ In a nutshell, the answer is to (a) identify which insureds are eligible for Medicare, and (b) gather and report all information required by CMS. The remainder of this article will address both of these points.

Step One

Determining Medicare Eligibility

The first obligation imposed upon primary plans is to identify which insureds are "claimants" who are entitled to Medicare. The MSPA defines a claimant as "an individual filing a claim directly against the applicable plan; and ... an individual filing a claim against an individual or entity insured or covered by the applicable plan."¹⁶ In other words, a "claimant" can be a first party insured filing a claim or a third party injured by the conduct of a primary payer's insured. Please note that if there is no claim made by or against an insured, primary payers have no obligations to report any information to CMS.¹⁷

After identifying an insured or injured party to be a "claimant," primary payers must determine if the claimant is eligible to receive Medicare benefits. Generally, there are four categories of individuals eligible for Medicare:¹⁸

- Persons who have reached age 65 and are entitled to receive either Social Security, widows or Railroad Retirement benefits;
- Persons of any age who have received Social Security, widows or Railroad disability benefits for 25 months;
- Persons with end-stage renal disease ("ESRD") who require dialysis treatment or a kidney transplant; and
- "[W]orking aged" persons over age 65 who are not eligible for either Social

Security or Railroad Retirement Benefits who purchase Medicare coverage by monthly payment as active employees for an employer of 20 or more employees.

Notably, the key question is not whether the claimant is actually receiving Medicare benefits, but merely if he or she *is eligible* for Medicare. If any claimant potentially falls within any of the four above categories, the primary payer's obligation is to gather information about this claimant and report this information to Medicare.

Step Two

Reporting Claimant Data to CMS

After identifying claimants eligible for Medicare, primary plans must submit information identifying each claimant and "such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim."¹⁹ Since August 2008, CMS has released four documents intended to shed light on precisely what information must be reported to CMS. These documents are: (1) the Mandatory Insurer Reporting Guidelines and a Supporting Statement; (2) an Implementation Timeline; (3) the Registration Process Instructions, and (4) an Interim Record Layout. It is imperative that primary payers review and understand these four documents and any additional documents released by CMS and made available online at <http://www.cms.hhs.gov/MandatoryInsRep/>.²⁰

On August 1, 2008, CMS issued its Mandatory Insurer Reporting Guidelines and a Supporting Statement. These documents set forth what information CMS wants primary payers to report and the process CMS intends to use to collect this data. The following is a summary of some important points contained in these documents.²¹

First, all MSPA reporting will be done electronically via a secure website that CMS is currently developing. Primary payers will be expected to compile a substantial amount of data concerning each single file, including:

- (1) Social Security Numbers or a Health Insurance Claim Numbers for each claimant;

(2) full contact information, dates of birth and, where applicable, dates of death, for all injured persons;

(3) full contact information on any estates, siblings or other representative claimants;

(4) legal name, type of coverage, full contact information, policyholder data, and policy limits for each type of coverage involved in the claim;

(5) full contact information for any attorneys involved in the claim;

(6) dates and the nature of any injuries, including whether the injury involved an allegedly defective product; and

(7) information detailing any resolution or settlement of a claim, with a particular focus on explaining whether the claim was contested or not, and whether the primary payer has assumed ongoing responsibility for medical costs associated with the claim.

While primary payers will be permitted to use agents, it is the primary payer, not the agent, who will be exclusively responsible for determining whether a claimant is eligible for Medicare and responsible for complying with the reporting of the above data.

On September 5, 2008, CMS released an Implementation Timeline, in which CMS revealed that it intends to develop the systems needed to facilitate mandatory reporting from January 2009 through June 2009.²² In May and June of 2009, primary payers will be expected to register online at CMS's mandatory reporting website.²³ Thereafter, CMS will test data submission at the website from July 2009 through December 2009.²⁴ All primary payers (liability/self/no-fault/workers' compensation insurers) must submit their first set of reports, which CMS refers to as "production files," from October 2009 through December 2009.²⁵ By January 1, 2010, all primary payers will have to submit their claimant data by that time.²⁶ Notably, this timetable reveals that CMS does not plan to have its reporting apparatus in place until months after July 1, 2009. However, primary payers should comply with the July 1, 2009 deadline.



To further explain the registration process, CMS released a set of Registration Process instructions on September 24, 2008. These instructions reiterate that all primary payers must register from May 1, 2009 through June 30, 2009.²⁷ CMS also instructs all primary payers to assign an “Account Manager” who will serve as an administrative contact with CMS.²⁸ The registration process will require each primary payer to provide information about itself, including contact information, lines of insurance, identification of its Account Manager and identification of any parent companies, subsidiaries or related companies.²⁹ **In addition, each primary payer will have to identify the approximate number of reported claims during the last calendar year that resulted in an actual payment to a claimant.**³⁰ This may require primary payers to compile statistical data that is not readily available. Thus, all primary payers should start this process immediately.

Lastly, on October 27, 2008, CMS issued an “Interim Record Layout.” This 60-page document lists technical and formatting requirements that primary payers must comply with in reporting to CMS. The Interim Record Layout describes the specific format that primary payers must utilize to report the data. While the information contained in the Interim Record Layout is extensive, it is nevertheless still quite preliminary, and CMS instructs all primary payers that “complete instructions and requirements will be published at a later date” and will be available online.³¹ In the Interim Record Layout, CMS lists a number of general requirements, some of which are summarized below. Again, primary payers are advised to review and become familiar with the Interim Record Layout and all documents released by CMS in connection with the MSPA’s reporting requirements.³²

The Interim Record Layout makes clear that CMS will require primary payers to adhere to strict formatting requirements. Moreover, all submissions must be made on a quarterly basis and within an assigned, 7-day submission period during each quarter. The submission window will be assigned upon registration. Initial submissions to CMS, which will take place from October 1, 2009 through December 31, 2009, must report on all claims involving a Medicare beneficiary resolved (or partially resolved) on or after July 1, 2009. However, if a claim is only

partially resolved by July 1, 2009, but the primary payer still has ongoing obligations to pay for medical services, that claim must be reported by June 30, 2010.³³

Primary payers have a 45-day grace period prior to the 7-day submission time period that will be assigned upon registration. As explained by CMS, “[f]or example, if the settlement date is May 1, 2010, and the file submission period for the second calendar quarter of 2010 is June 1-7, 2010, then the [primary payer] may delay reporting that claim until the third calendar quarter file submission during September 1-7, 2010. However, if the settlement date is April 1, 2010, then the [primary payer] must include this claim on the second calendar quarter file submission during June 1-7, 2010.”³⁴

Lastly, all files may be submitted using Hypertext Transfer Protocol over Secure Socket Layer (HTTPS), Secure File Transfer Protocol (SFTP), or for large files, via Connect:Direct and the AT&T Global Network System (AGNS). Primary payers are advised to present these issues to their IT staff as soon as possible so that they may begin preparing for this process.

In sum, MSPA compliance will require each primary payer to stay abreast of CMS’ instructions, and will require a diligent effort to compile all of the data needed for reporting purposes. Primary payers must develop protocols to identify claimants entitled to Medicare and establish systems to enable the collection, compilation, and technical transmission of data requested by CMS. Primary payers are encouraged to implement some of the following suggested protocols:

1. Primary payers must review and, where necessary, revise, their initial intake protocols to ensure that they obtain all of the information they need to determine if a claimant is eligible for Medicare.

2. Primary payers must designate an employee to serve as an Account Manager and serve as an administrative contact with CMS.

3. Primary payers must work with their IT staff *now* to start developing software that will assist in compiling the data required by CMS. By referencing CMS’ Supporting Statement,

Interim Record Layout, and this article, primary payers can determine what information is necessary and ascertain the most cost-effective ways to retrieve and compile this data. In addition, IT staff must also develop data transmission protocols and ensure that primary payers can properly store, transmit and receive large volumes of data.

4. Primary payers should strongly consider retaining records for at least ten years as per the recommendation of CMS.

5. Any and all settlement agreements must contain provisions that reflect that the parties have accounted for Medicare’s interests during their negotiations and details as to how the agreement achieves this end should be enumerated in any settlement agreement.³⁵

6. Primary payers should turn to counsel, internal personnel, or both, and task them with remaining abreast of instructions and guidance from CMS.

7. Primary payers must implement procedures to investigate and remain informed of any conditional payments by Medicare on any of their claims. Keeping track of any such payments will be necessary for a variety of reasons, including: (a) keeping a log of what costs may need to be repaid to Medicare, (b) calculating an appropriate reserve in handling the file, and (c) identifying whether excess carriers, if any, must be afforded notice of potential claims.

8. Primary payers must develop training protocols to ensure that all staff charged with the task of reporting data to CMS are aware of the numerous formatting and technical requirements for submission of reports. In addition, forms and templates should be created to ensure uniformity and assist in compliance.



9. Primary payers should develop internal procedures for preparing reports to CMS. Primary payers may consider creating a workgroup or division dedicated exclusively to CMS reporting. Alternatively, primary payers may wish to require each Adjuster to assume this task for each of his or her claims files.

10. Primary payers should create internal guidelines to determine whether the creation of Medicare Set Aside Trusts are needed for a particular claim. Primary payers are encouraged to work with counsel in making these determinations.

CONCLUSION

Primary payers must act diligently in complying with the MSPA's reporting requirements. The alternative is exposure to substantial fines. Primary payers are encouraged to remain abreast of updates and instructions at <http://www.cms.hhs.gov/MandatoryInsRep/> and to communicate regularly with counsel regarding MSPA compliance.

Endnotes

1 CMS uses multiple acronyms to refer to parties that are responsible for complying with the MSPA's reporting requirements. Some of these terms are Responsible Reporting Entities ("RRE") or non-GHP entities (all RREs except for group health plans). Rather than use these terms, this article utilizes the term "primary payers" throughout this article.

2 This article does not address the obligations imposed upon Group Health Plans ("GHP"). GHPs are also subject to the MSPA's new reporting requirements, and must commence reporting to CMS on and after January 1, 2009.

3 See Parasher B. Patel, CMS Memorandum to All Regional Administrators, *Workers Compensation Commutation of Future Benefits*, July 23, 2001.

4 Medicare Set-Asides are described in section 411 of Title 42 of the Code of Federal Regulations, which provides as follows:

If a lump-sum compensation award stipulates that the amount paid is intended to compensate the

individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump sum payment. 42 C.F.R. §411.

5 See Popolizio, Mark, *Liability Cases and Medicare Compliance*, June 2008, at p. 5, available at www.nqbp.com.

6 CMS defines the term "total settlement amount" to include wages, attorney's fees, all future medical expenses and repayment of any conditional payments by Medicare. Gerald Walters, *CMS Memorandum to All Regional Administrators, Workers Compensation Medicare Set-Aside Arrangement (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries*, April 25, 2006.

7 CMS defines reasonable expectation to include three scenarios: (1) when the applicant has applied for SSD, (2) when the applicant has been denied SSD but anticipates appealing this denial or re-filing, and (3) where the claimant is 30 months away from the age of Medicare eligibility or where the claimant has End State Renal Disease at any age. Thomas L. Grissom, CMS Memorandum to All Regional Administrators, *Medicare Secondary Payer - Workers Compensation (WC) Frequently Asked Questions, FAQ No. 2*, April 22, 2003.

8 See Popolizio, Mark, *Liability Cases and Medicare Compliance*, at p. 4, (June 2008), available at www.nqbp.com.

9 See *Glover v. Liggett Group, Inc.*, 459 F.3d 1304, 1306 (11th Cir. 2006) (quoting *Cochran v. U.S. Health Care Financing Admin.*, 291 F.3d 775, 777 (11th Cir. 2002)).

10 42 U.S.C. § 1395y(b)(2)(A).

11 See 42 U.S.C. § 1395y(b)(2)(A)(i) (authorizing conditional payments by Medicare); 42 C.F.R. § 411.21 (defining the term "promptly" to mean 120 days from the date of medical service or the filing of an insurance claim, whichever commences earlier).

12 Under the MSPA, the federal government can sue any entity for failure to reimburse Medicare. See 42 U.S.C. § 1395y(b)(2)(B)(iii). The federal government also has a statutory right of subrogation as to any Medicare beneficiary. 42 U.S.C. § 1395y(b)(2)(B)(iv). In addition, the MSPA also creates a private right of action that entitles parties to collect double damages where an entity fails to provide primary payment or reimbursement of covered medical costs. See 42 U.S.C. § 1395y(b)(3)(A); *Glover*, 459 F.3d at 1307.

13 The MSPA's reporting provision is codified at 42 U.S.C. § 1395y(b)(8).

14 42 U.S.C. § 1395y(b)(8)(E)(i).

15 The focus of this article is on suggesting steps to comply with the MSPA's reporting requirements. Other important topics, such as how to calculate a Medicare set-aside, are beyond the limited scope of this article. For a discussion as to whether tortfeasors can be subject to the MSPA's requirements, see the article entitled "The Medicare Secondary Payer Act and Its Affect on Tort Cases", Cole, Scott & Kissane, P.A., *Litigation Quarterly* (March 2008) at p. 7, available at <http://www.csklegal.com/articles/Anniversary%20Issue.pdf>.

16 42 U.S.C. § 1395y(b)(8)(D).

17 *Id.*

18 See 42 U.S.C. § 1395c (2008); 42 C.F.R. §§405.340-341; *Frazer v. CNA Ins. Co.*, 374 F.Supp.2d 1067, 1071 n.2 (N.D. Ala. 2005); *Cooper v. Blue Cross and Blue Shield*, 19 F.3d 562 (11th Cir. 1994).

19 See 42 U.S.C. § 1395y(b)(8).

20 See 73 Fed. Reg. 45013, 45014 (August 1, 2008); Supporting Statement at p. 1.

21 All bullet-point references are derived from Attachment D of the Supporting Statement.

22 Implementation Timeline, at p. 2.

23 Implementation Timeline, at p. 2.

24 Implementation Timeline, at p. 2.

25 Implementation Timeline, at p. 2.

26 Implementation Timeline, at p. 2.

27 Registration Process, at p. 2.

28 Registration Process, at p. 2.

29 Registration Process, at p. 3-6.

30 Registration Process, at p. 7.

31 Interim Record Layout, at p. 2 and see also Popolizio, Mark, CMS Releases "Interim Record Layout" Information For Reporting Under Section 111 of the MMSEA, October 2008, available at www.nqbp.com.

32 Interim Record Layout, at p. 4-6.

33 Interim Record Layout, at p. 7.

34 Interim Record Layout, at p. 7.

35 This suggestion was contained in Popolizio, Mark, *Liability Cases and Medicare Compliance*, June 2008, available at www.nqbp.com. Mr. Popolizio's has published several articles on MSPA compliance.

NON-DELEGABLE DUTIES OF HOSPITALS

By Genevieve Rupelli



A new strategy that Plaintiffs are employing, in an attempt to hold hospital surgical centers actively liable, is to contend that pursuant to the applicable common, statutory, and licensing laws of the State of Florida, hospitals and surgical centers have a non-delegable duty to provide medical care and services. Yet, the general rule is that hospitals do not owe a duty to their patients to provide physicians' medical and surgical care. Under the common law, a hospital is not liable for the negligent acts of a physician who is not its employee, but instead an independent contractor.¹ Plaintiffs who attempt to plead that a non-delegable duty is owed would not be successful under current Florida common law.

However, Plaintiffs are now asserting that hospitals should be held liable for their physicians under a broad interpretation of certain Florida

statutes and regulations. Florida Statute Section 395.002(13)(b) defines "Hospital" as "any establishment that regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care or other definitive medical treatment..." Further, Chapter 395, Florida Statutes, authorizes the Agency for Health Care Administration (AHCA) to adopt rules and regulations to ensure that hospitals are operated consistent with established standards and rules.² Rule 59 A-3.2085(4) of Florida's Administrative Code requires each Class I, Class II, and Class III hospital providing surgical or obstetrical services to have "an anesthesia department, service, or similarly titled unit directed by a physician member of the organized professional staff." Based on the statute and regulation, Plaintiffs have argued that a non-delegable duty of hospitals to provide non-negligent surgical treatment exists.

The Courts agreed with this rationale in *Wax v. Tenet Health Systems Hospitals, Inc.*,³ when it imposed a non-delegable duty on a hospital to provide anesthesia services to surgical patients consistent with the established standards.⁴ The case further holds that such a duty cannot be avoided by delegating these services to an independent contractor.⁵

42 C.F.R. § 482.1 is another source that Plaintiffs are utilizing to impose a non-delegable duty on hospitals based on the hospitals participation in the federal Medicare program. This regulation is designed to ensure that medical services are provided in a safe and effective manner (even if those services are provided by independent contractors). It was promulgated by the U.S. Department of Health & Human Services' Centers for Medicare and Medicaid Services to govern a hospital's eligibility to receive payments from

the Medicare program. In an effort to combat plaintiffs' attempts to derive a basis for liability against a hospital from this regulation, defendants point to the legislative intent of the regulation. Such an analysis reflects that the underlying intent of the regulation was to set forth requirements for hospitals to participate in the Medicare and Medicaid Programs, not to give rise to a private right of action by patients who allege injuries at the hands of the physicians that merely occur in a hospital setting.

While Florida appellate courts have been silent on the plaintiffs' theory regarding 42 C.F.R. § 482.12, other courts have rejected the plaintiffs' theory outright. In *Acevado v. Lifemark Hospital of Florida*,⁶ the trial court opined that the Medicare regulations do no more than require a hospital to staff its hospital competently. Any non-delegable duty of the hospital would be limited to providing competent physicians rather than ensuring non-negligent care.⁷ In *Blackmon v. Tenet Healthsystems Spalding*,⁸ the court held that the regulation does not purport to impose state tort liability on hospitals for the negligence of their independent contractors. Rather, it simply outlines the guidelines with which the hospitals must comply to receive Medicare.

Finally, plaintiffs have relied on a contractual argument to attempt to impose a non-delegable duty upon hospitals. Under Florida law, a hospital may undertake to contract to provide certain types of care to its patients. If it does so, the contractual duty to provide such care may not be delegated to independent contractors even though the actual performance may be delegated. In *Irving v. Doctors Hosp. of Lake Worth, Inc.*,⁹ the court recognized that a hospital that undertakes a contract obligation to do something is not allowed to escape contractual liability by delegating performance to an independent contractor.

In recent years, Florida's First, Fourth, and Fifth District Courts of Appeal have analyzed the contractual language contained in the forms executed by patients and their hospital. These courts have issued three radically different views of a hospital's contractual duty to its patients. In *Shands Teaching Hosp. and Clinic, Inc. v. Juliana*,¹⁰ the court upheld a summary judgment imposing liability on a hospital for the negligence of a perfusionist based on a theory of contractual non-delegable duty. The court's analysis of the non-delegable duty question drew a clear distinction between physicians' services and care rendered by nurses or technologists, including perfusionists.¹¹ In this case, the hospital clearly discharged liability for the negligence of the physicians, residents, and students in the employ of the University of Florida, but this was not the case with the perfusionsists.¹² The court noted that patients normally contract separately for physicians' services, but do not normally contract separately for the services of hospital-based nurses and technologists.¹³ In *Pope v. Winter Park Healthcare Group, Ltd.*,¹⁴ the court determined that Florida law does not currently recognize

an implied non-delegable duty on the part of a hospital to provide competent medical care to its patients.¹⁵ A consent form that notified the patient that the physicians were independent contractors, and not agents or employees of the hospital, and also delegated the performances of services physicians normally provide, was not legally sufficient to discharge the duty to provide medical care.¹⁶ Specifically, the consent form was absent any language indicating that the patient was discharging the hospital from liability.¹⁷ Finally, in *Wax v. Tenet Health Systems Hospitals, Inc.*, the court reasoned that the hospital's duty to provide anesthesia care was pursuant to both contract and state statutes and regulations.¹⁸ In *Wax*, a surgical consent form authorized in part to the administration of anesthesia services by a professional association of anesthesiologists during surgery.¹⁹ The court distinguished this consent form from the one used in *Pope*.²⁰

In conclusion, while there is little support for a common law cause of action against hospitals and surgical centers, Plaintiffs have successfully brought statutory and contractual actions.

Endnotes

- 1 *Pub. Health Trust of Dade County v. Valcin*, 507 So. 2d 596, 601 (Fla. 1987).
- 2 § 395.1055 (1)(d), Fla. Stat.
- 3 955 So. 2d 1 (Fla. 4th DCA 2007).
- 4 *Id.*, at 9.
- 5 *Id.*
- 6 2005 WL 1125306 (Fla. 11th Cir. Ct. May 5, 2005).
- 7 *Id.*
- 8 653 S.E. 2d 333 (Ga. Ct. Appl. 2007).
- 9 415 So. 2d 55 (Fla. 4th DCA 1982).
- 10 863 So. 2d 343 (Fla. 1st DCA 2003).
- 11 *Id.*
- 12 *Id.*
- 13 *Id.*
- 14 939 So. 2d 185 (Fla. 5th DCA 2006).
- 15 *Id.*, at 187.
- 16 *Id.*
- 17 *Id.*
- 18 955 So. 2d 1, 9 (Fla. 4th DCA 2007).
- 19 *Id.*; The surgical consent form was on the hospital's letterhead.
- 20 *Id.*

WILL WORKERS' COMPENSATION CLAIMS BECOME FEE DRIVEN IN FLORIDA?

By Dara Jebrock and Jennifer Vicedo



the current state of the law governing awards of attorney's fees in workers' compensation actions. Part I of this article will provide a historical overview of the attorney's fees provision of the Workers' Compensation Act (the "Act").⁵ Part II will analyze the decision rendered in *Murray v. Marnier Health*. Lastly, part III will evaluate the legal and practical implications that may result from *Murray v. Marnier Health*.

STATUTORY HISTORY OF THE ATTORNEY'S FEE AWARD UNDER THE WORKERS' COMPENSATION ACT

Since the Act was enacted, the Florida Legislature has undertaken various efforts to supplement and amend the Act as it pertains to attorney's fee awards.⁶ "The

Workers' Compensation Act was originally passed as an administrative legislation to be simple, expeditious, and inexpensive so that the injured employee, his family, or society generally, would be relieved of the economic stress resulting from work-connected injuries, and place the burden on the industry which caused the injury."⁷ Originally, a claimant under the Act would be responsible for his or her own attorney's fees.⁸ However, in an effort to protect a claimant's compensation award under the Act, the Legislature (from the original adoption of the Act), provided the Judge of Compensation Claims ("JCC") or relevant administrative body, the authority to oversee the amount of attorney's fees paid to a claimant's attorney.⁹

The Supreme Court of Florida directly addressed the method for determining the reasonableness of an attorney's fee award under the Act in the seminal case of *Lee Engineering*

and Construction Company v. Fellows.¹⁰ In *Lee Engineering*, the Court held that a strict application of a contingent percentage of the benefit award was inappropriate in this area of the law and, thus, a reasonable attorney's fee award should be determined through the application of the factors governing attorneys' fees enumerated in Rule 4-1.5(b) of the Rules Regulating the Florida Bar (Fees and Costs for Legal Services).¹¹ Consequently, the Legislature amended the Act in 1977 to incorporate the factors set forth in Rule 4-1.5 and codified this amendment as section 440.34 of the *Florida Statutes* (the "Statute").¹² However, the Legislature also amended the Act to provide a statutory formula to be applied initially in determining a reasonable attorney's fee award for a successful claimant.¹³ Accordingly, to determine the reasonableness of an attorneys' fee award under the 1977 version of section 440.34 "the JCC applied the formula and then increased or decreased the amount after consideration of the factors"¹⁴

Only two years later, the Legislature, made some significant changes to section 440.34.¹⁵ Specifically, although the Legislature ensured that the reference to the fee formula and the *Lee Engineering* factors remained in subsection (1), the Legislature deleted any direct reference to the award of employer and/or carrier-paid fees when the claimant prevailed over the employer and/or carrier's denial of compensation.¹⁶ Rather, "[t]he Legislature moved the provision for an employer/carrier-paid attorney's fee award into subsection (2) and listed three specific instances¹⁷ that would trigger a claimant's 'entitlement' to an attorney's fee award to be paid by the employer/carrier."¹⁸ "Nothing in subsection (2) referred directly to the formula or factors of subsection (1)."¹⁹

On October 23, 2008, the Supreme Court of Florida rendered a landmark decision in *Murray v. Marnier Health and Ace USA*,¹ ruling that attorneys are entitled to "reasonable" fees in workers' compensation insurance cases.² In reaching its decision, the Court found that the significant amendment made to Florida Statute Section 440.34 in 2003 created a statutory ambiguity as to specific instances that would entitle a workers' compensation claimant to an attorney's fee award to be paid by his or her employer or insurance carrier in the event the claimant prevailed in an action involving compensation claims.³ Business advocacy groups are concerned that the Court's decision in *Murray* may result in an influx of fee driven workers' compensation cases and increased insurance costs for Florida employers.⁴ This article will examine the controversy surrounding

Subsequently, in 1980, the foregoing provision regarding employer and/or carrier-paid attorney's fees was renumbered in subsection (3).²⁰ It was not until 1986 that the Legislature linked the statutory formula and the *Lee Engineering* reasonableness factors of subsection (1) to an attorney's fee award.²¹ Specifically, the Legislature added the following sentence to subsection (2) of section 440.34:

In applying the factors set forth in subsection (1) to cases arising under paragraphs (a), (b), and (c) of this subsection, the deputy commissioner shall only consider such benefits and the time reasonably spent in obtaining them as were secured for the claimant within the scope of paragraphs (a), (b), and (c) of this subsection.²²

While section 440.34 was amended several other times, the Legislature made the most significant and substantive changes in 2003.²³ In particular, in the 2003 amendment, "the Legislature deleted reference to consideration of the reasonable fee factors and made other changes" in subsection (1).²⁴ However, the Legislature deleted the sentence in subsection (3) referencing the application of the formula and reasonableness factors in subsection (1) that was previously added in 1986.²⁵ The 2003 amendment purported to limit the attorneys' fees, which could be paid to prevailing claimants, to a strict percentage of the benefits secured through the attorneys' efforts.²⁶ As such, after the 2003 amendment, and as of today, section 440.34, provides, in pertinent part, as follows:

(1) A fee, gratuity, or other consideration may not be paid for a claimant in connection with any proceedings arising under this chapter, unless approved as reasonable by the judge of compensation claims or court having jurisdiction over such proceedings. Any attorney's fee approved by a judge of compensation claims for benefits secured on behalf of a claimant must equal to **20 percent of the first \$5,000 of the amount of the benefits secured, 15 percent of the next \$5,000 of the amount of the benefits secured, 10 percent of the remaining amount of the benefits secured to be provided during the first 10 years after the date the claim is filed, and 5 percent of the benefits secured after 10 years.** The judge of compensation claims shall not approve a compensation order, a joint stipulation for lump-sum settlement, a stipulation or agreement between a claimant and his or her attorney, or any other agreement related to benefits under this chapter that provides for an attorney's fee in excess of the amount permitted by this section. The judge of compensation claims is not required to approve any retainer agreement between the claimant and his or her attorney. The retainer agreement as to fees and costs may not be for compensation in excess of the amount allowed under this section.

...

(3) If any party should prevail in any proceedings before a judge of compensation claims or court, there shall be taxed against the nonprevailing party the reasonable costs of such proceedings, not to include attorney's fees. A claimant shall be responsible for the payment of her or his own attorney's fees, except that a ***claimant shall be entitled to recover a reasonable attorney's fee from a carrier or employer:***

(a) Against whom she or he successfully asserts a petition for medical benefits only, if the claimant has not filed or is not entitled to file at such time a claim for disability, permanent impairment, wage-loss, or death benefits, arising out of the same accident;

b) In any case in which the employer or carrier files a response to petition denying benefits with the Office of the Judges of Compensation Claims and the injured person has employed an attorney in the successful prosecution of the petition;

(c) In a proceeding in which a carrier or employer denies that an accident occurred for which compensation benefits are payable, and the claimant prevails on the issue of compensability; or

(d) In cases where the claimant successfully prevails in proceedings filed under s. 440.24 or s. 440.28.²⁷

However, section 440.34(3) does not define "reasonable attorney's fee."²⁸ Further, subsection (1) and subsection (3) are not cross-referenced within the Statute.²⁹ "Rather, subsection (3) authorizes reasonable attorney's fees without any mention of the formula."³⁰ Consequently, "when the formula requirement of subsection (1) is read together with the reasonable attorney's fee authorization of subsection (3), a statutory ambiguity is created."³¹

THE CASE FOR CONTROVERSY: *MURRAY V. MARNIER HEALTH*

A. *The Underlying Proceedings*

In *Murray*, the Supreme Court of Florida invalidated the 2003 amendment to section 440.34 and ruled that a court must apply the *Lee Engineering* factors in determining the reasonableness of fees to be awarded to a prevailing workers' compensation claimant.³² In *Murray*, the petitioner, a certified nursing assistant, sustained an injury after assisting a co-worker in lifting a patient.³³ Specifically, the petitioner "was diagnosed with a uterine prolapse and underwent a hysterectomy."³⁴ This case arose after the petitioner's petition for workers' compensation benefits, including costs and attorney's fees, was denied by the petitioner's employer and its insurance carrier, the respondents.³⁵ At an administrative hearing, the respondents asserted that the petitioner was

not entitled to workers' compensation benefits, arguing, among other things, that the petitioner's injuries did not occur during the scope of employment.³⁶ In addition, the respondents argued that they did not owe the petitioner fees, costs, or interest.³⁷ However, the JCC disagreed with the respondents and awarded the petitioner \$3,244.21 in benefits.³⁸

As the prevailing party in the underlying workers' compensation action, the parties agreed that the petitioner was entitled to an award of attorneys' fees from the respondents pursuant to section 440.34 but disputed the method by which the fee award should be calculated by the JCC.³⁹ At a subsequent hearing to determine the amount of fees to be awarded, the petitioner argued that the *Lee Engineering* factors should be considered by the JCC in determining the reasonableness of the amount of fees to be awarded, even though subsection (1) of section 440.34 no longer set forth factors for determining the reasonableness of attorneys' fees.⁴⁰ In opposition, the respondents argued that the attorneys' fee amount should be calculated based on the contingency fee formula set forth in subsection (1).⁴¹

Evidence presented at the hearing showed that the customary rate of pay for attorneys' fees in workers' compensation cases involving similar complex issues was \$200.00 per hour.⁴² Further, testimony was presented that if the JCC strictly applied the formula set forth in subsection (1), the petitioner would only be entitled to \$8.11 an hour for her attorney's efforts, who spent approximately eighty (80) hours working on the petitioner's case.⁴³ Although the JCC recognized that applying the statutory formula set forth in subsection (1) would appear "manifestly unfair[,]," the JCC nevertheless applied the formula and entered an order awarding the petitioner \$684.84 in attorneys' fees.⁴⁴ Of significance, the JCC noted that if it applied the *Lee Engineering* factors, a reasonable fee would have been \$16,000.00 (\$200.00 an hour multiplied by eighty (80) hours).⁴⁵ On appeal, and relying on well-established precedent at that time, the First District Court of Appeal affirmed the JCC's order awarding the petitioner \$684.84 in attorneys' fees.⁴⁶

B. Supreme Court of Florida Grants Certiorari Review

The Supreme Court of Florida granted *certiorari* review to determine how a claimant's attorneys' fee award should be calculated under section 440.34 when a claimant prevails in a workers' compensation action against an employer or insurance carrier.⁴⁷ In conducting its analysis, the Court reviewed the plain



language of the Statute and determined that a statutory ambiguity existed when the formula requirement of subsection (1) was read together with reasonable attorneys' fee authorization of subsection (3).⁴⁸ To resolve the obvious ambiguity, the Court looked to the legislative history of the Statute, public policy, legislative intent, and the fundamental principles of statutory construction.⁴⁹ The Court specifically noted that "[i]f we construed subsection (3) as being controlled by the formula of subsection (1), the reasonable attorneys['] fees requirement of subsection (3) would be rendered meaningless and absurd because the application of the formula in all cases would result in inadequate fees in some cases and excessive fees in other cases."⁵⁰ Thus, the Court held that the *Lee Engineering* factors should be considered in determining a claimant's reasonable attorneys' fees because "[i]nadequate fees and excessive fees are not reasonable attorney fees."⁵¹

CONCLUSION

Prior to the Supreme Court of Florida's ruling in *Murray*, under the 2003 amendment to section 440.34 and relevant Florida case law, an attorney representing an injured worker was only entitled to recover a statutory percentage of the benefits paid to the claimant.⁵² The 2003 amendment addressed, among other things, extensive fraud and noncompliance with workers' compensation coverage requirements and steadily increasing costs.⁵³ A key component of claim costs prior to the 2003 amendment was hourly attorneys' fees, which made the cost of litigated claims forty (40) percent higher in Florida than in any other state because of the increased litigation.⁵⁴ The 2003 amendment linked attorneys' fees to the value of benefits secured through a fee percentage schedule, eliminating the ability of claimant attorneys to bill by the hour.⁵⁵ *Murray* has now overturned the 2003 amendment and effectively restored hourly attorneys' fees for the claimant, thereby triggering one of the prime drivers of claim costs—excessive attorney involvement.⁵⁶ Thus, it appears that in light of the Court's holding in *Murray*, workers' compensation

claims may now become fee driven.⁵⁷

ENDNOTES

1 No. SC07-244, slip op. (Fla. Oct. 23, 2008).

2 *Id.* at 2.

3 *Id.* at 2, 20.

4 South Florida Business Journal, Florida Supreme Court Issues Ruling Regarding Attorneys' Fees in Workers' Comp Cases, <http://southflorida.bizjournals.com/southflorida/stories/2008/10/20/daily45.html> (last visited Oct. 28, 2008).

5 FLA. STAT. ch. 440 (2008).

6 See generally FLA. STAT. § 440.34 (2008) (legislative history).

7 *Lee Eng'g & Constr. Co. v. Fellows*, 209 So. 2d 454, 456 (Fla. 1968).

8 *Murray*, No. SC07-244 at 11.

9 See ch. 17481, § 34, Laws of Fla. (1935); see also *Murray*, No. SC07-244 at 11.

10 209 So. 2d 454, 458–59.

11 *Id.*; see also R. REGULATING THE FLA. BAR 4-1.5

12 Ch. 77-290, § 9, at 1293–94, Laws of Fla. (codified at FLA. STAT. § 440.34 (1977)). Specifically, section 440.34(1) was amended as follows:

(1) If the employer or carrier shall file notice of controversy as provided in s. 440.20, or shall decline to pay a claim on or before the 21st day after they have notice of same, or shall otherwise resist unsuccessfully the payment of compensation, and the claimant injured person shall have employed an attorney at law in the successful prosecution of the claim, there shall, in addition to the award for compensation, be awarded a reasonable attorney's fee of 25 percent of the first \$5,000 of the amount of the benefits secured, 20 percent of the next \$5,000 of the amount of the benefits secured, and 15 percent of the remaining amount of the benefits secured, to be approved by the judge of industrial claims, which fee may be paid direct to the attorney for the claimant in a lump sum. However, the judge of industrial claims shall consider the following factors in each case and may increase or decrease the attorney's fee if in his judgment the circumstances of the particular case warrant such action:

(a) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(b) The likelihood, if apparent to the claimant, that the acceptance of the particular employment will preclude employments of the lawyer by others or cause antagonisms with other clients;

(c) The fee customarily charged in the locality for similar legal services; (d) The amount involved in the controversy and the benefits resulting to the claimant;

(e) The time limitation imposed by the claimant or the circumstances; (f) The nature and length of the professional relationship with the claimant;

(g) The experience, reputation, and ability of the lawyer or lawyers performing the services;

(h) The contingency or certainty of a fee.

Id. (additions underlined; deletions struck through).

13 *Id.*

14 *Murray*, No. SC07-244 at 14. See generally FLA. STAT. § 440.34 (1977).

15 See generally ch. 79-40, § 27, at 252–53; ch. 79-312, § 15, at 1656–57, Laws of Fla. (1979).

16 *Id.*

17 Under the 1979 amendment, entitlement to fees were triggered in the following three instances:

1) against whom she or he successfully asserts a petition for medical benefits only, if the claimant has not filed or is not entitled to file at such time a claim for disability, permanent impairment, wage-loss, or death benefits, arising out of the same accident; 2) in cases where the deputy commissioner issues an order finding that a carrier had acted in bad faith with regard to handling an injured worker's claim and the injured worker has suffered economic loss. For the purposes of this paragraph, 'bad faith' means conduct by the carrier in the handling of a claim which amounts to fraud, malice, oppression, or willful, wanton or reckless disregard of the rights of the claimant. Any determination of bad faith shall be made by the deputy commissioner through a separate fact-finding proceeding; or 3) in a proceeding where a carrier or employer denied that an injury occurred for which compensation benefits are payable, and the claimant prevails on the issue of compensability.

FLA. STAT. § 440.34(2)(a)–(c) (1979).

18 *Murray*, No. SC07-244 at 15.

19 *Id.*

20 See ch. 80-236, § 14, Laws of Fla.; FLA. STAT. § 440.34(3) (Supp. 1980).

21 Ch. 86-171, § 4, Laws of Fla. (1986).

22 *Id.*

23 See ch. 2003-412, § 26, Laws of Fla. (effective Oct. 1, 2003).

24 *Id.*

25 *Id.*

26 Florida Workers' Compensation Lawyer, Florida Supreme Court Invalidates 2003 Amendment to Attorney's Fee Statute, <http://www.flworkerscompensationlawyer.com/2008/10/articles/attorneys-fees/florida-supreme-court-invalidates-2003-amendment-to-attorneys-fee-statute/#more> (last visited Nov. 3, 2008).

27 FLA. STAT. § 440.34(1), (3) (2008) (emphasis added).

28 *Murray v. Mariner Health & Ace USA*, No. SC07-244, slip op. at 2 (Fla. Oct. 23, 2008).

29 Compare § 440.34(1), with § 440.34(3).

30 *Murray*, No. SC07-244 at 10.

31 *Id.* at 9.

32 *Id.* at 2, 20.

33 *Id.* at 2.

34 *Id.*

35 *Murray*, No. SC07-244 at 2–3.

36 *Id.* at 3.

37 *Id.*

38 *Id.*

39 *Id.* at 5.

40 *Murray*, No. SC07-244 at 5.

41 *Id.*

42 *Id.* at 5–6.

43 *Id.* at 6–7.

44 *Id.*

45 *Murray*, No. SC07-244 at 7.

46 *Id.* at 7–8.

47 *Id.* at 1, 9.

48 *Id.* at 9–20.

49 *Id.* at 19.

50 *Murray*, No. SC07-244 at 19.

51 *Id.*

52 Florida Injury Victim Lawyer Blog, Florida's Supreme Court Rules in Favor of Injured Workers, http://www.floridainjuryvictimlawyerblog.com/2008/10/floridas-supreme-court-rules_i_1.html (last visited Nov. 3, 2008).

53 Insurance Journal, Florida Supreme Court Overturns Workers' Comp Attorney Fee Limits, www.insurancejournal.com/news/southeast/2008/10/24/94950.htm (last visited Nov. 3, 2008).

54 *Id.*

55 *Id.*

56 *Id.*

57 *Id.*

THE FEDERALLY SUPPORTED HEALTH CENTERS ASSISTANCE ACT AND INSURANCE COVERAGE



By Miles A. McGrane, IV

The Federally Supported Health Centers Assistance Act (“Act”) allows the United States to “deem” actors, agencies and employees to be part of the Public Health Service (“PHS”). Such “deemed” actors qualify for a type of limited insulation from suit under the Federal Tort Claims Act (“FTCA”).

The facility, called an “entity” under the Act, and its employees enjoy the Act’s protection by being “deemed” employees of the PHS. A facility does not enjoy immunity simply by virtue of receiving federal funds. It must take affirmative steps to obtain immunity. This is done by applying to the Secretary of Health and Human Services (“HHS”), who then makes the determination of whether or not the entity meets the requirements to be “deemed” a PHS employee.

The relevant code sections specifically delineate four requirements for the Secretary of HHS to determine whether an entity should be deemed to be a part of the PHS: (1) the Secretary must find that the entity has implemented appropriate policies and procedures for reducing the risk of malpractice; (2) the entity must have reviewed and checked the credentials of its physicians and other health care practitioners; (3) the entity must have no claims filed against the United States as a result of this Act, or if so, the entity must have cooperated fully with the Attorney General and taken corrective steps to assure that such claims will not arise in the future; and (4) the entity must cooperate with the Attorney General and provide information

that will help the Attorney General estimate the amount of claims that will arise during the year.

In determining what action to take when handling a file that might involve FTCA protection, the insurer should make two initial determinations: (1) the insurer needs to consider whether the file involves a facility or an individual; and (2) whether the issue involved is a claim being filed or a simple evaluation of the insured’s coverage.

The insurer should also realize how the FTCA affects the relationship between the insurer and its insured. The purpose of the Act is to eliminate the facility’s need for private medical malpractice insurance. However, facilities will still need “gap” insurance to cover those acts or omission outside the FTCA. Where an insured fails to properly obtain FTCA protection, a claim that could have been covered by the FTCA would then have to be handled by the insurer under any “gap” coverage. Additionally, any procedural miscue on the part of the facility that disqualifies an entity’s application, will preclude FTCA coverage for the facility and its employees. Therefore, the insurer has an incentive to make sure that the facility follows all the proper procedures for obtaining FTCA protection.

Once an insurer handles a claim involving a health care facility, it is too late to seek immunity for a facility that has not been deemed a PHS entity by the Secretary of HHS. The insurer should contact the facility to determine whether it has been through the deeming process. If the facility has not been deemed, it of course will not receive FTCA protection. If the facility has been deemed, the insurer should make certain that the insured’s facility notifies the federal government of the adverse suit or claim. This should be done regardless of whether the claim is an actual suit or simply a notice of intent.

If the insurer is not handling a pending claim or lawsuit, but rather is evaluating coverage, the insurer should find out if the facility receives federal funding that would qualify it for protection under the Act. If the facility

meets the Act's statutory requirements, the insurer should make sure the facility begins and completes the deeming process. There is no statutory protection until the deeming process has been completed. The insurer should further determine the portion of the facility's services that will be devoted to federal health care and accordingly covered by federal funding. Such a determination allows the insurer to give the facility the appropriate discount on its premiums since a certain portion of medical services will be excluded from coverage under the policy.

The Act covers acts or omissions, relating to the grant-supported activity, occurring after the date the entity becomes a deemed facility and related to the grant-supported activity. Determination of two key elements is essential to establishing facility coverage under the Act: (1) the date the facility was deemed an employee under the Act; and (2) whether the alleged act or omission that forms the basis of the claim is related to the scope of services funded by the grant.

Any statutory protection is not retroactive and only applies to acts or omissions occurring on or after the date the Secretary deemed the facility to be an employee of the PHS. Even after a health care facility is deemed an employee of the PHS, the health care facility is not protected under the FTCA from all suits brought against it. The protection only extends to services related to the grant-supported activity. This is known as being within the "Scope of Project." When a health care facility faces a cause of action, it must notify the Attorney General of the claim or lawsuit so that the Attorney General can determine whether the Act covers the particular incident.

Once the Attorney General receives notification of a lawsuit against any entity or one of its employees, the Attorney General has fifteen (15) days to make an appearance in court to advise the court whether the entity or its employees are deemed PHS employees for the purposes of the acts or omissions at issue in the suit. If the Attorney General finds that the entity or its employees are PHS employees, such finding will satisfy the Act's requirements that the Attorney General certify that the entity and its employees were acting within their scope of employment. Thus, the PHS employees would receive the Act's protection. If the acts are not related to the federal funding, then neither the entity nor the individual will receive protection from the federal government.

It is possible for the Act to protect an entity and not cover a physician performing services at

the health care facility. The Act provides that an individual may be considered a contractor of the entity if the individual meets certain criteria:

The Act defined a Public Health Service employee to include "an entity described in [§ 233(g)(4)], and any officer, governing board member, or employee of such an entity, *and any contractor of such an entity who is a physician or other licensed or certified health care practitioner* (subject to paragraph 5)."¹

Paragraph (5) states:

An *individual* may be considered a contractor of an entity ... only if...

A) The *individual* normally performs on average of at least 32 1/2 hours of service per week for the entity for the period of the contract. § 233(g)(5); or

B) In the case of an *individual* who normally performs less than 32 1/2 hours of service per week for the entity for the period of the contract, the *individual* is a licensed or certified provider of services in the fields of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.²

Conceivably, a physician who is not an employee of the health care facility may perform services related to the facility's federal funding. If the facility had completed the deeming process, it should be covered by the Act; however, the physician would not be covered because he is neither an actual employee nor meets the requirements to be considered a contractor.

A finding that the facility or physician is an employee allows the Attorney General to remove the case to federal district court, with the substitution of the United States as the defendant. At this point the United States will take over the case and the entity or individual's involvement will be limited to cooperating with the United States in defending the lawsuit.

The Act protects health care facilities and their employees by deeming them PHS employees, which means that the sole remedy against them is to bring suit against the United States pursuant to the FTCA. In cases involving deemed entities, even though the United States is substituted as the defendant, it is vital for a health care facility to understand how the FTCA works because the facility and its employees will often remain involved in the suit. In cases where the United States substitutes itself for an entity or

employee of the facility, the original defendant will be expected to cooperate fully so that the United States can adequately defend the case. Moreover, in cases where a health care facility maintains dual coverage, the private insurer will have an additional interest in the outcome of the case because the United States may seek payment from the insurer for any judgment against the United States pursuant to a statutory right of subrogation.

CONCLUSION

While the Act does provide some coverage/immunity for medical malpractice claims, a facility covered under the Act still needs additional insurance coverage for several reasons. Facilities will still need "gap" insurance to cover those acts or omission that fall outside the FTCA. Where an insured fails to properly obtain FTCA protection, a claim that could have been covered by the FTCA would then have to be handled by the insurer under any "gap" coverage. Additionally, any procedural miscue on the part of the facility, should it disqualify the application, will preclude FTCA coverage for the facility and its employees.

Moreover, the Act only covers acts or omissions occurring after the date the entity becomes a deemed facility and related to the grant-supported activity. Any statutory protection is not retroactive and only applies to acts or omission occurring on or after the date the Secretary deemed the facility to be an employee of the PHS. Even after a health care facility is deemed an employee of the PHS, the health care facility is not protected under the FTCA from all suits brought against it. The protection only extends to services related to the grant-supported activity, and the determination as to whether the Act covers the particular incident is within the discretion of the Attorney General.

Finally, it is possible for the Act to protect a facility and not cover a physician performing services at the health care facility. If the physician in question is neither an actual employee nor meets the requirements to be considered a contractor under the Act, then coverage would not be provided.

ENDNOTES

1 42 U.S.C. § 233(g)(1)(A).

2 42 U.S.C. § 233(g)(5).

THE CHANGING FACES OF INDEMNITY PROVISIONS IN CONSTRUCTION CONTRACTS

By Valerie Jackson

In 1972, the Florida legislature enacted section 725.06, Florida Statutes, which places limitations on indemnification in construction contracts.¹ Although this statute remained unchanged for eighteen years, in the last decade, it appears that the legislature has struggled with this notion of indemnification in construction contracts. As a result, the statute has gone through various changes. Whether a particular indemnity provision in a construction contract is valid largely depends on the year in which a contract was executed. Below please find a synopsis of the changes to date.

The Original Version of the Statute

From 1972-2000, indemnity provisions in construction contracts were valid if the contract contained a monetary limit on indemnity *and* was part of the project specifications or bid documents, if any specification or bid documents exist² *or* if the person being indemnified gave specific consideration for the indemnification and it was provided for in the contract and section of the project or specifications or bid documents, if any. Subsections (1) and (2) are stated in the disjunctive, and the satisfaction of either one is sufficient to render an otherwise invalid construction contract indemnification clause enforceable under the statute.³ Furthermore, the "specific consideration" required by section 725.06(2) need not be a dollar amount. In *Westinghouse Electric Corporation v. Turnberry Corporation*,⁴ the court held that early delivery of elevators, ahead of schedule, constituted "specific consideration" within the meaning of the statute. Courts have also held that the payment of a percentage amount pursuant to the agreement would satisfy the requirements of that section.⁵

The 2000 Amendment to the Statute

In 2000, the statute was amended for the first time.⁶ Some argue, the 2000 amendment constituted a radical change because it made

unenforceable and void any indemnity provision which required one party to indemnify any other party for its own negligence.⁷ Instead, the only provisions that were valid were those which sought to hold the indemnifying party liable for its wrongful acts (negligence, recklessness or intentional misconduct) and those under the indemnifying party's control.⁸ The 2000 version of the statute was, in effect, a codification of common law indemnity principles which would not be applicable to an independent contractor.⁹

The Current Version of the Statute

In 2001, the statute was again amended and remains in its current form.¹⁰ The current version of the statute now allows indemnification where



the wrongful conduct was caused, in whole or in part, by the indemnifying party so long as the contract contains a monetary limitation that bears a reasonable relationship to the contract and is part of the contract specifications or bid documents, if any.¹¹ As to indemnification to owners of real party by persons in privity with the owner shall not be less than \$1 million dollars per occurrence unless agreed upon by the parties.¹² The statute also limits the scope of indemnification by excluding claims of, or damages resulting from, gross negligence, or willful, wanton, or intentional misconduct of the indemnitee, its officers, directors, agents, or employees, or for statutory violation or punitive damages except and to the extent the statutory violation or punitive damages are

caused or result from the acts or omissions of the indemnitor, their agents, employees, and those working under them.¹³

CONCLUSION

In sum, when evaluating a tender of indemnification, a practitioner should first determine whether the indemnity provision is valid pursuant to the particular version of the section 725.06, Florida Statute that governs the execution of the subject contract. While an indemnity provision may, for example, contain the requisite consideration or monetary limitation it may still be invalid because another version of the statute applies to the particular contract. The operative fact for determination as to which version of the statute applies is the date of execution of the contract.

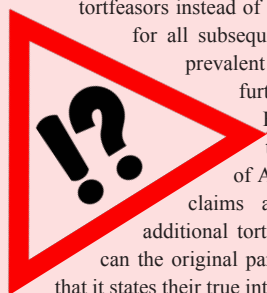
ENDNOTES

- 1 Section 725.06, Florida Statutes (1972).
- 2 *Peoples Gas System, Inc. v. RSH Constructors, Inc.*, 563 So.2d 107 (Fla. 1st DCA 1990).
- 3 See, *Westinghouse Electric Corporation v. Turnberry Corporation*, 423 So.2d 407 (Fla. 4th DCA1983); *Peoples Gas System, Inc. v. RSH Constructors, Inc.*, 563 So.2d 107 (Fla. 1st DCA 1990).
- 4 423 So.2d 407 (Fla. 4th DCA 1982).
- 5 *Pacific Nat. Equity Co. v. Montgomery*, 367 So.2d 729 (Fla. 4th DCA 1979); *Peoples Gas System, Inc. v. RSH Constructors, Inc.*, 563 So.2d 107 (Fla. 1st DCA 1990.) and *MacIntyre v. Green's Pool Service, Inc.*, 347 So.2d 1081 (Fla. 3d DCA 1977).
- 6 Section 725.06, Florida Statutes (2000).
- 7 *Id.*
- 8 *Id.*
- 9 See generally, *Paul N. Howard Co. v. Affholder, Inc.* 701, So.2d 402, 404 (Fla. 5th DCA 1997).
- 10 Section 725.06, Florida Statutes (2001).
- 11 *Id.*
- 12 *Id.*
- 13 *Id.*

RELEASE OF ALL CLAIMS: MUTUAL MISTAKE

By Tara Tamoney

Once a settlement is reached, the tortfeasor who has settled with the victim will usually request that the victim sign a Release of All Claims. There are circumstances where there are multiple tortfeasors, and the victim may choose to seek compensation from all tortfeasors instead of holding the original tortfeasor responsible for all subsequent acts causing injury. This situation is prevalent when an already injured victim is injured further by a subsequent medical provider.



However, an issue may arise if the original tortfeasor and the victim signed a Release of All Claims that releases all of the victim's claims against additional tortfeasors. Can all additional tortfeasors prevail on summary judgment or can the original parties reform the Release of All Claims so that it states their true intentions?

The Fifth District Court of Appeal recently addressed this issue in *Banks v. Orlando Regional Healthcare*.¹ In *Banks*, the Banks family was involved in a serious automobile accident with another vehicle driven by Guyette.² Guyette and his insurer settled for his policy limits.³ The release stated that the Banks agreed to release all claims against Guyette and his insurer from liability of all known and unknown, foreseen and unforeseen injuries resulting from the automobile accident.⁴ The release was silent regarding any subsequent claims the Banks had against additional parties.⁵ After the settlement monies were deposited, the Banks filed suit against the health care providers who treated their daughter who had been injured in the accident.⁶ The health care providers filed a motion for summary judgment claiming that the Banks released all subsequent tortfeasors in the original release.⁷ The Banks opposed the motion and filed an Amended Release of All Claims against Guyette and his insurer which preserved their claims against subsequent tortfeasors.⁸

Similarly in *Rucks v. Pushman*,⁹ Rucks was injured by Pushman outside of a bar owned by Gailey.¹⁰ After Rucks was taken to the hospital for her injuries, she was injured further by the hospital.¹¹ Rucks filed suit against Pushman, Gailey and the health care providers.¹² After Rucks settled with and released Pushman and Gailey, the health care providers filed motions for summary judgment claiming that they were released from all claims as a result of the releases between Rucks, Pushman and Gailey.¹³

A victim may first settle with the initial tortfeasor solely for the injuries suffered from the initial tort and then sue the subsequent health care providers.¹⁴ A release of only the initial tortfeasor should be "carefully accomplished so that it is clear that the victim is not receiving compensation from the initial tortfeasor for injuries resulting from the subsequent negligence of the health care providers and that the victim is reserving the victim's cause of action against the health care providers."¹⁵ If the release does not clearly and unequivocally preserve the victim's claims against health care providers, it is assumed that the victim recovered from the initial tortfeasor for all the injuries suffered by the health care providers, and thus, the victim will be barred from claiming a cause of action against the health care providers.¹⁶ The court in *McCutcheon v. Hertz Corp.* stated that if the settlement agreement

between the victim and initial tortfeasor was intended to compensate the victim just for injuries caused by the initial tortfeasor, and not to compensate the victim for injuries from subsequent health care providers, the victim should be able to establish their intention.¹⁷ The cause of action, if any, that the victim may have against the initial tortfeasor to reform the victim's release, should be asserted in a separate equitable reformation action.¹⁸

A court in equity has the power to reform a written instrument where, due to mutual mistake, the instrument as drawn does not accurately express the true intention or agreement of the parties to the instrument. Notably, in reforming a written instrument, an equity court in no way alters the agreement of the parties. Instead, the reformation only corrects the defective written instrument so that it accurately reflects the true terms of the agreement actually reached.¹⁹

In order to reform an agreement, evidence must be presented to make obvious, by clear and convincing evidence, that there was a mistake of fact between the parties.²⁰

In *Banks*, the court concluded that any "unintended assignment" of the Banks' claims against the health care providers was "cured" by the reformation.²¹ In *Rucks*, the health care providers' motions were granted.²² The court affirmed the summary judgments since Rucks did not bring a separate equitable reform action.²³ Many plaintiff attorneys are not aware that a separate action in equity is required to reform a release and rather attempt to challenge the release in litigation. In this case, the court should follow *Rucks* and grant the subsequent tortfeasor's motion for summary judgment. The court should find that the victim released the subsequent tortfeasors because equitable relief was not obtained.

ENDNOTES

- 1 955 So. 2d 604 (Fla. 5th DCA 2007).
- 2 *Id.* at 605.
- 3 *Id.*
- 4 *Id.*
- 5 *Id.*
- 6 *Id.* at 606.
- 7 *Id.*
- 8 *Id.*
- 9 541 So. 2d 673 (Fla. 5th DCA 1989).
- 10 *Id.* at 674.
- 11 *Id.*
- 12 *Id.*
- 13 *Id.*
- 14 *Id.* at 675.
- 15 *McCutcheon v. Hertz Corp.*, 463 So. 2d 1226 (Fla. 4th DCA), rev. denied, 476 So. 2d 674 (Fla. 1985).
- 16 *Id.* at 676.
- 17 *Id.*
- 18 *Banks*, 955 So 2d at 608 (citing *McCutcheon*, 476 So. 2d at 676).
- 19 *Banks*, 955 So 2d at 608.
- 20 *Newman v. Metropolitan Dade County*, 576 So. 2d 1352 (Fla. 3rd DCA 1991).
- 21 *Banks*, 955 So 2d at 609.
- 22 *Rucks*, 541 So. 2d at 674-675.
- 23 *Id.* at 676.

FLORIDA SUPREME COURT AFFIRMS “PATIENTS’ RIGHT TO KNOW”

By Lonni Tessler



representatives of any such committee.²

Amendment 7 was promoted as an aid for consumers and patients in making informed decisions in selecting a health care provider. In November 2004, Amendment 7 was passed by more than 81% of Florida voters and was incorporated into Article 10, Section 25 of the Florida Constitution.³

After the passage of Amendment 7, the Florida Legislature implemented Section 381.028, Florida Statutes in an attempt to preserve the confidentiality of peer review records created before the amendment was adopted. Numerous conflicting opinions from various Florida District Courts of Appeal arose in the courts’ attempts to reconcile the Amendment with Section 381.028. The Florida Supreme Court’s 2008 opinion in *Florida Hospital Waterman, Inc. v. Buster*⁴ resolved those conflicts.

In *Waterman*, the Florida Supreme Court held that Amendment 7 on its face provided a sufficient rule by which patients would be able to gain access to records of a health care provider’s adverse medical incidents.⁵ The Florida Supreme Court went on to state that the amendment expressly declared that it was effective on passage without the need for legislative action.⁶

The Supreme Court also stated that this Amendment mandates access to existing adverse medical incident records.⁷ The Supreme Court did not favor the term “retroactive” because it was somewhat confusing in the context since a patient who may have benefited from the Amendment cannot go back in time to make an informed decision on medical care.⁸ However, the Supreme Court adopted the First District’s statement in *Notami Hospital of Florida v. Bowen*, stating: “Because the plain language of the amendment expresses a clear intent that it be applied to include records created prior to its effective date, doing so is not an unconstitutional retroactive application.”⁹ Moreover, the Supreme Court concurred with the First District in its conclusion that “the Hospital does not have a vested right in maintaining the confidentiality of adverse medical incidents. The Hospital’s ‘right’ is no more than an expectation that previously existing statutory law would not change.”¹⁰

Lastly, in agreement with the First District, the 4-3 majority opinion¹¹ struck down several statutory provisions of Section 381.028, Florida Statutes that attempted to limit effect of the Amendment, finding that: (1) the statute only allowed for final reports to be discoverable, while the amendment provides that “any records” relating to adverse incidents are subject to the amendment; (2) the statute only provided for disclosure of final reports related to the same or a substantially similar condition, treatment, or diagnosis with that of the patient requesting access; (3) the statute limited production to only those records generated after November 2, 2004; and (4) the statute stated that it had no effect on existing privilege statutes.¹² The Supreme Court further indicated that in addition to those four limitations, the statute provided that patients

can only access the records of the facility or provider of which they themselves are a patient, a restriction not contained within the amendment.¹³ The Supreme Court held that the unconstitutional subsections of Section 381.028, Florida Statutes could be severed without the need to strike down the entire implementing statute.¹⁴

This recent Florida Supreme Court decision substantially changes Florida law, resulting in a significant setback for health care providers. For decades, health care providers had relied on statutory discovery protections to protect the confidentiality of peer review information. However, the Supreme Court firmly held that Amendment 7 eliminated existing statutory discovery protections, leaving health care providers wondering what, if any, protections remain for the peer review process.

In sum, Amendment 7 only applies to records. Amendment 7 does not eliminate the statutory immunity for participation in peer review activities and require the disclosure of the identities of peer review committee members, and thus, this information remains confidential.

ENDNOTES

- 1 Article X, Section §25 of the Florida Constitution.
- 2 *Id.*
- 3 Fla. Dep’t of State, Div. of Elections, Nov. 2, 2004 General Election, *Official Results*, <http://election.dos.state.fl.us/elections/resultsarchive/>
- 4 *Florida Hospital Waterman, Inc. v. Buster*, 984 So.2d 478 (Fla. 2008).
- 5 *Id.* at 486.
- 6 *Id.*
- 7 *Id.* at 492.
- 8 *Id.* at 486.
- 9 *Id.* at 487 citing *Notami Hospital of Florida v. Bowen*, 927 So.2d 139, 145 (Fla. 1st DCA 2006).
- 10 *Id.* at 492 citing *Notami Hosp.*, 927 So.2d at 143-44.
- 11 This is important because Governor Charlie Crist will appoint four Supreme Court Justices in the new term.
- 12 *Id.* at 493 citing *Notami Hosp.*, 927 So.2d at 143.
- 13 *Id.*
- 14 *Id.* at 493-494.

THE EFFECTS OF THE LAPSE PERIOD OF FLORIDA'S NO FAULT LAW

By Lori Riviere

On October 1, 2007, the Florida Motor Vehicle No-Fault law requiring Florida automobile owners to carry Personal Injury Protection ("PIP") coverage sunsetted. Several days after the No-Fault law expired, the Florida Legislature enacted a bill to revive the No-Fault law effective January 1, 2008. However, the legislature's bill re-enacting the No-Fault law created a lapse period from October 1, 2007 through December 31, 2007. The lapse period affects automobile negligence cases for accidents that occurred during said period.

The effect of the lapse period on the No-Fault exemption

The No-Fault Law provides an exemption from tort liability and damages for motor vehicle owners and registrants and certain related covered persons from tort actions for pain, suffering, mental anguish and inconvenience arising out of the automobile accident unless the injured person can show:

- Significant and permanent loss of an important bodily function;
- Permanent injury, other than scarring or disfigurement;
- Significant and permanent scarring or disfigurement; or
- Death.¹

The lapse period eliminated any exemption from tort liability and damages for motor vehicle owners and registrants who obtained or renewed insurance policies between October 1, 2007 and December 31, 2007. Therefore, a plaintiff suing an alleged tortfeasor for injuries sustained in an automobile accident does not need to prove any permanent loss of bodily function, permanent injury, significant scarring or death to recover damages from the alleged tortfeasor. A plaintiff suing for an accident that occurred during the lapse period in the PIP statute has a very low threshold upon which to show damages in order to recover. Any injury, even a momentary loss of consciousness or a concussion with no lasting effects, would be enough to recover damages if negligence is proven.

As stated above, one purpose of the PIP Statute was to make insurance compulsory and in doing so provide a reasonable alternative to the traditional action in tort where one had to prove fault. Under the PIP statute, the injured party is assured of recovery of his or her major and salient economic losses from his own insurer, namely his lost wages and medical bills. Thus, the insured can recover something "even where he himself is at fault" and that normally there will be a speedy payment rather than prolonged litigation. When PIP is not mandatory, and there is no requisite to prove permanency, a jury is free to award the medical specials, as well as pain and suffering

without having ever determined that the Plaintiff was permanently injured. The lapse period eliminates the need for a plaintiff to prove permanency with regard to injuries. Therefore, as a result, plaintiff's may recover pain and suffering damages for any injury regardless of severity or permanency.

The effect of the lapse period on the PIP set-off

Florida's No-Fault law requires automobile registrants to carry ten thousand dollars (\$10,000) of PIP coverage. Said coverage provides policy holders, resident relatives and occupants of a vehicle involved in an accident who do not have their own coverage with ten thousand dollars (\$10,000) worth of medical treatment for injuries sustained as a result of the accident. This results in a ten thousand dollar (\$10,000) set-off of damages awarded by a jury. Damages awarded in lawsuits for accidents affected by the lapse period do not have any set-off.²

CONCLUSION

Overall, policies written or renewed during the No-Fault lapse period increase exposure for potential defendants in automobile negligence cases and this increased exposure must be considered when evaluating the litigation strategy of a lawsuit where the lapse period is applicable. For example, in an automobile negligence case without the \$10,000 PIP set off, or the criteria that permanency must be proven by the plaintiff, the case automatically has a value equal to the medical specials, and continues to increase in value depending on the facts, the alleged injuries, the plaintiff's believability. Therefore, automobile negligence cases arising from accidents that occurred during the lapse period must be evaluated differently taking the potential for increased exposure into account.

ENDNOTES

- 1 Section 627.736, Florida Statutes (2007).
- 2 *Allstate Ins. Co. v. Rudnick*, 706 So. 2d 389 (Fla. 4th DCA 1998).

Barry Postman and Julie Kornfield obtained a Dismissal in a Broward County Fair Housing case, establishing a finding of no reasonable cause to believe that a discriminatory housing practice occurred. The Claimant's Fair Housing Complaint contained allegations of discrimination based on the Claimant's mother's disability. Barry and Julie successfully argued that the Claimant's request for an accommodation was not necessary but merely preferred under the circumstances. By aggressively taking this position, Barry and Julie convinced the Broward County Office of Equal Opportunity to recommend a finding of no reasonable cause.

Dan Shapiro and Lara Dabdoub obtained a defense verdict in a medical malpractice case in which they represented two nurses and their supervising doctor who allegedly caused the death of a 34-year-old father-to-be during a surgical procedure. Dan and Lara successfully argued to the jury that the patient suddenly crashed and there was no way to predict or anticipate the change coming.

Michael Shiver and Karly Spira obtained a final summary judgment in favor of a West Palm Beach law firm and its attorney in a legal malpractice and tortious interference claim.

Dan Shapiro and Bryan Rotella obtained a directed verdict after five days of trial. They represented a paramedic from Pasco County who was sued for allegedly dropping the patient causing a fracture of the hip and subsequent death.

Barry Postman and Miles McGrane obtained a dismissal with prejudice in two separate lawsuits filed by the same employee against the same employer. The initial lawsuit was filed in the United States District Court and based upon allegations that the Plaintiff was a whistleblower and wrongfully terminated in violation of ERISA. The dismissal was by way of a Motion to Dismiss based upon a Statute of Limitations argument. The second case that was dismissed was a Florida RICO case filed in Broward County Circuit Court. The basis for the dismissal was the failure of the Plaintiff to meet the stringent requirements of bringing a RICO cause of action. The Plaintiff's demand was two million dollars prior to the time that each of his separate causes of action were dismissed.

Luisa M. Linares successfully obtained an affirmance of a Broward County trial court order granting Defendant's motion to dismiss the complaint with prejudice for failure to plead a cause of action.

Michael E. Brand and Ashley Sybesma received a wonderful verdict before Judge Mark Jones in Key West. They represented an oil company and the driver of their tanker truck who broadsided the Plaintiff's pickup truck while carrying 1,000 gallons of diesel fuel in an at-fault accident. As a result of the accident, Plaintiff claimed a herniated disk in his neck, herniated disk in his back and an ongoing seizure disorder which caused him to lose his job. The Plaintiff's medical bills were over \$50,000. After a three-day trial, the jury returned a verdict for the Plaintiff of only \$97,000 (which will be reduced by \$10,000 for a PIP setoff). The plaintiff's pretrial demand was \$200,000 and the defense had a proposal for settlement which was effective for any award under \$100,000.

Robert Malani obtained a final summary judgment in a real estate malpractice case. The case involved a failed commercial real estate transaction in which the Plaintiff-buyer claimed that the Defendant-realtor, made misrepresentations that induced the Plaintiff to enter into the contract, and which caused the Plaintiff to incur damages. The trial court found that such misrepresentations were covered in the contract, and entered judgment in favor of the realtor as a matter of law. The trial court also denied the Plaintiff's motion for leave to amend, on the basis that such amendments would be futile.

John Coleman and Tullio Iacono received a favorable outcome from arbitrator John Finn, Esquire in a non-binding arbitration. The case involved the death of a resident from a nursing home facility six days following his discharge from the facility. He died from sepsis involving MRSA pneumonia. They were able to show the arbitrator that even though the Decedent had a very large sacral ulcer at the time of his discharge from the facility, the resident received from the facility proactive care in terms of communication with family, communication with physicians, and assessment of new conditions.

Barry Postman and Julie Kornfield obtained a Dismissal in a Palm Beach County Fair Housing case, establishing a finding of no reasonable cause to believe that a discriminatory housing practice occurred. The Claimant's Fair Housing Complaint contained allegations of discrimination based on the Claimant's disability. Barry and Julie successfully argued that the Claimant's request for an accommodation was not reasonable under the circumstances. By aggressively taking this position, Barry and Julie convinced the Office of Equal Opportunity to dismiss the Fair Housing Complaint.

Ron Campbell and Julie Kornfield obtained a Dismissal in a Palm Beach County Fair Housing case, establishing a finding of no reasonable cause to believe that a discriminatory housing practice occurred. The Claimant's Fair Housing Complaint contained allegations of discrimination and harassment based on the Claimant's disability. Ron and Julie successfully argued that the Association acted solely to compel the Claimant's compliance with its governing documents. By aggressively taking this position, Ron and Julie convinced the Palm Beach County Office of Equal Opportunity to dismiss the Fair Housing Complaint as the evidence did not demonstrate that the Claimant was discriminated against based on his disability.

Barry Postman and Katie Merwin obtained a finding of no cause in a Fair Housing Complaint. The Claimant's Complaint contained causes of action sounding in gender discrimination. Barry and Katie successfully argued that the facts alleged by the Claimant were insufficient to sustain any cause of action for discrimination. By aggressively taking the position that the Association treats their unit owners uniformly, Barry and Katie convinced the investigator from the Lee County Office of Equal Opportunity to enter a finding of no cause and dismiss the case.

Henry Salas and Clarke Surge obtained a verdict significantly lower than Plaintiff's demand in Broward County. Plaintiff was claiming she suffered from mesothelioma as a result of being exposed to asbestos. Pursuant to the jury's apportionment of liability, the Defendant we are representing is only responsible for \$1,081,800.00. The Plaintiff had demanded \$14.5 million and in a recent case tried by the same Plaintiff's lawyers also in Broward County, they received a verdict of \$27.4 million.

Jami L. Gursky and Joseph A. Wolsztyniak were able to have the Plaintiff voluntarily dismiss the case against the optometrist in a professional malpractice lawsuit after they filed the Motion to Dismiss for failure to comply with proper pre-suit procedures under Florida Statute Section 766.106.

Joseph A. Wolsztyniak was successful in a non-binding arbitration showing that our client, the Defendant-subcontractor, was not liable for Plaintiff's damages resulting from a trip and fall. The Plaintiff alleged that the subcontractor failed to perform its work in a reasonably safe manner because the subcontractor left plywood not flush with the floor of a shopping mall, which continued to remain open during construction. Joseph argued that the subcontractor performed the work and secured the site, as requested by the contractor, pursuant to the request of the mall owner. Plaintiff landed on both knees and required three separate arthroscopic knee surgeries and medical bills totaling almost \$150,000.00. Plaintiff demanded \$400,000.00 before arbitration and allowed our \$25,000.00 Proposal for Settlement to expire. The arbitrator found that

the mall owner was 100% at fault for the accident and no liability was assessed against the subcontractor. Plaintiff was awarded \$250,000.00 in damages.

Luisa M. Linares successfully obtained an affirmance of a Sarasota County trial court order denying Plaintiff's motion for new trial alleging improper jury experimentation with the evidence during deliberations. Aram P. Megerian and Kendra Shaw of our Tampa Office obtained the order denying the new trial in the court below.

Michael E. Brand and Jami L. Gursky obtained a complete defense verdict after a six-day trial. The Plaintiff argued that a condominium owner was acting as an agent and on behalf of his wife (a board member) and the condominium itself when he attacked a neighboring condo board member during a dispute over a common sprinkler pump. The Plaintiff, who had just undergone a partial mastectomy, was punched in the breast and has incurred over \$50,000 in medical expenses. Four years later, she is still seeking treatment. The Plaintiff asked the jury for \$900,000. Although the jury determined that the attack did occur, the jury found that the assailant was not an agent nor acting on behalf of the other parties and that there was no liability against the Defendants.

Barry Postman and Jeff Alexander obtained an excellent verdict in a four-day trial in Punta Gorda, Florida. The Plaintiff, without dispute, suffered from RSD and was without the use of her left arm as a result of the subject accident. The Plaintiff also alleged significant economic damages. The demand to the jury was approximately 1.4 million dollars. The jury found our client 1.5% responsible of \$358,000. This amounts to a verdict of about \$5,400. We had previously served a proposal for settlement for \$25,000 and, therefore, will be able to collect the fees and costs.

Scott A. Cole and John Penton obtained a dismissal with prejudice in a legal malpractice practice action brought by the excess carrier against the primary insured's attorney. The Court agreed with our position that there was no duty that ran between the primary insured's attorney and the excess carrier. The only legal duty that existed was between the primary insurer and the excess carrier.

Announcements

David Salazar was re-inducted as the Co-Chair for the Young Lawyers Division of the Florida Defense Lawyers Association for 2008 to 2009.



NEWS AND NOTES



October is the National Down Syndrome Awareness Month and in honoring the children, adults and families of a loved one with Down Syndrome, Cole Scott and Kissane, P.A. ("CSK") was a 2008 Corporate Sponsor of the 2008 Miracle Walk held on October 12, 2008 in Coral Gables, Florida. Not only was CSK a corporate sponsor, but we also had many participants from the Miami and Ft. Lauderdale office take part which made up "TEAM ALYSSA." Two-year old Alyssa Knapp who has Down Syndrome and is the daughter of our very own Robert Knapp in the Miami office led "TEAM ALYSSA" through the streets of Coral Gables in honor of the Miracle Walk. This year there were over 2,500 attendees. The proceeds of the event go to the less fortunate families of a loved one with Down Syndrome in order that the loved one can receive the proper medical and therapeutic services so that they can enjoy and experience life to its fullest. Additional proceeds are also given to programs to help educate expecting mothers of a Down Syndrome baby and to new mothers of a Down Syndrome child in order to assist in educating the family.

Last year, more than \$130,000 was raised and went toward advocacy workshops for parents of children with Down Syndrome, providing support of the National Down Syndrome Society, welcoming parents of new babies born with Down Syndrome in Miami-Dade County with gift baskets, including books and other constructive information, various therapy gift certificates, and hosting play dates.

We will look forward to all of you joining us in walking with the 2009

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