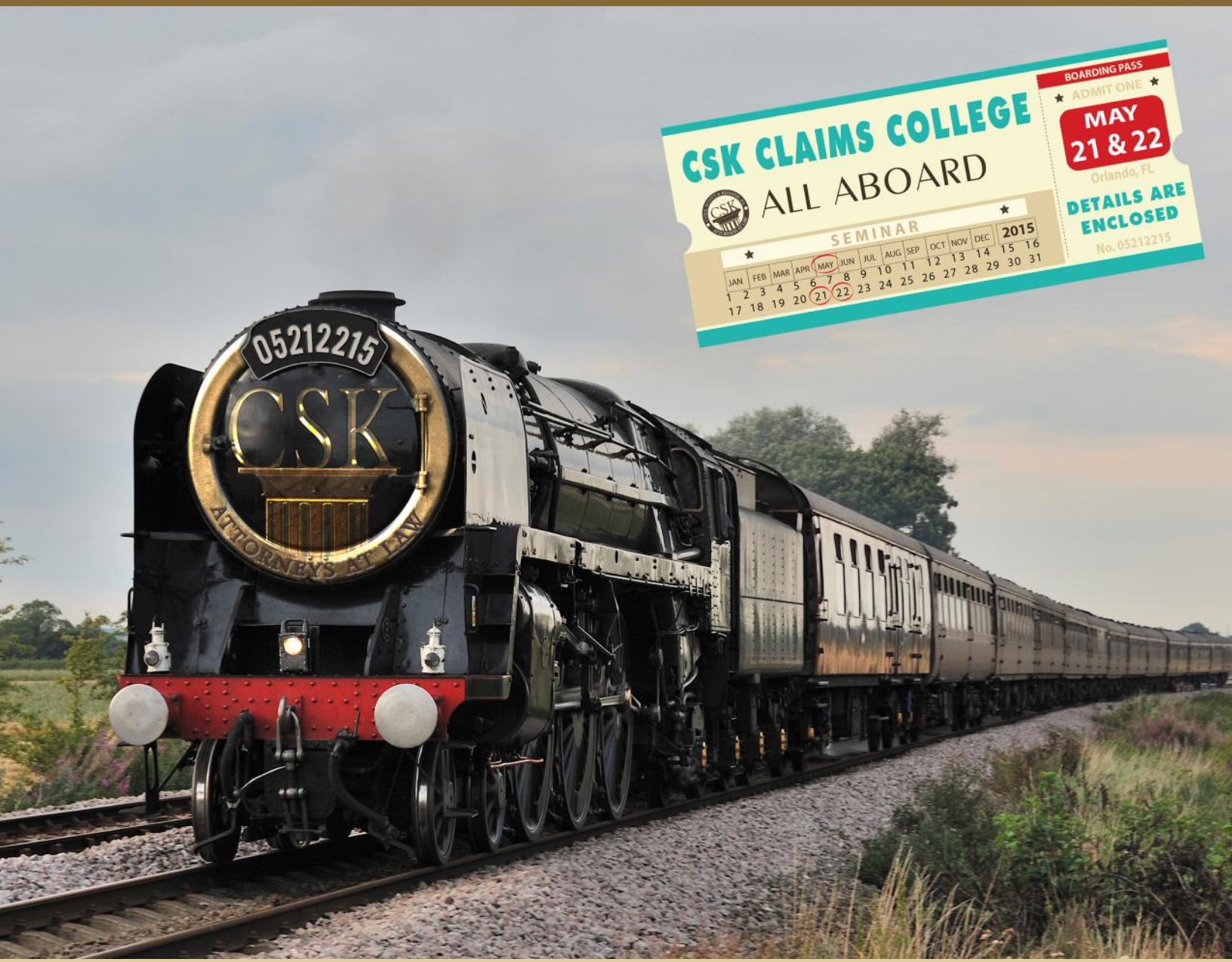
QUARTERLY
Newsletter

COLE, SCOTT & KISSANE, P.A. | SPRING 2015



Insurance Brokers, Agents and Dual Agents: How to Avoid Being Bound

How the Concept of Emergency Medical Conditions Is Changing the Florida No-Fault Personal Injury Protection Landscape

Fighting Back: What Are Letters of Protection? Why Are They Important? And How Do You Use Them To Attack The Reported Medical Charges And Illustrate The Financial Bias Between Treating Physicians and Plaintiffs' Counsel?

The Examination Under Oath Awakens

FROM THE OFFICES OF COLE, SCOTT & KISSANE, P.A.

PRACTICE AREAS

Accounting Malpractice
Admiralty/Maritime
Aviation
Appellate
Arbitration, Alternative Dispute Resolution and Mediation
Architects and Engineers
Bad Faith and Extra-Contractual Liability
Banking and Financial
Business/Commercial Law
Civil Rights Law
Class Actions
Commercial Litigation
Condominium Law
Construction Law
Corporate, Transactional & Real Estate
Directors and Officers
Education Law
Employment & Labor
Environmental
Federal Practice
Fidelity and Surety Litigation & Counsel
First Party Property Defense
Fraud Litigation
General Civil Litigation
Government Relations
Homeowners' Association
Hospitality Industry Defense
Insurance Coverage & Carrier Representation
Intellectual Property
Land Use Litigation and Real Property Disputes
Legal Malpractice
Liquor Liability Defense
Medicare Secondary Payer Compliance
Nursing Home/Health Care
Nursing Malpractice
Physician's Malpractice
Premises Liability
Product Liability
Professional Liability
Residential Homeowner Defense
Securities
SIU Insurance Fraud Defense
Trucking Accident Defense
Vehicle Negligence
Workers' Compensation

IN THIS ISSUE

Trivia Question

True or False: A Letter of Protection is an agreement between a plaintiff and their treating provider stating that payment will be made from the monies collected at the conclusion of litigation.

The first ten readers to respond correctly will receive a free CSK tote.

- **Please respond by email to Quarterly.Trivia@csklegal.com**
- **Please remember to include your name and address with your entry.**
- **The contest deadline is June 15, 2015.**
- **See the last page for Official Contest Rules.**

A Note from the Assistant Editor

Dear Readers,

Thank you for your continued interest in our Quarterly. Our publication is the result of a firm-wide effort. It draws upon the combined legal experience of over 280 lawyers and provides opportunities for our Associates to work closely with our Partners strengthening our commitment to mentorship and professional growth. Beyond that, it gives all of us at CSK an opportunity to create a discourse about current trends in litigation and their impacts with our clients, colleagues, and prospective clients.

This issue is exciting because it introduces us to a few of the many topics to be discussed at CSK's All Aboard 2015 Claims College Seminar, such as how the concept of emergency medical conditions is changing PIP and the importance of letters of protection in attacking past medical damages. These are just two examples of the many topics that are at the forefront of current litigation trends CSK Attorneys tackle on a daily basis. Furthermore, this issue also introduces me as your Assistant Editor.

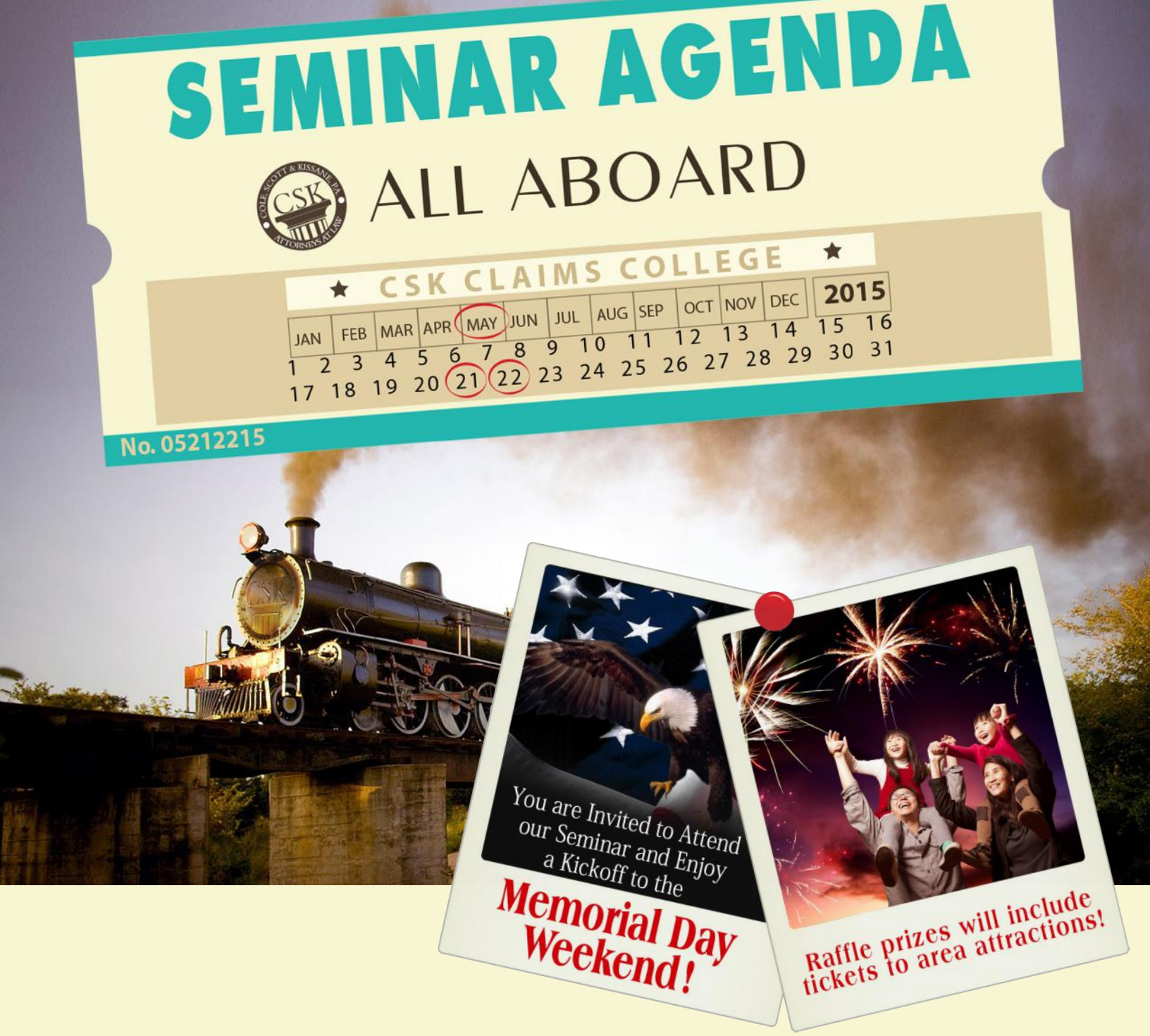
Lastly, I want to thank all of our many readers who participated in our last Quarterly Trivia Contest. The answer was "false." Congratulations to all of the well-informed and lucky winners who received a CSK Tumbler. Please be sure to respond to this Edition's Trivia Contest for your chance to win. We look forward to hearing from you.

Sincerely,

Brittany P. Borck

Editors

Eric Rieger, Esq., Editor - **Brittany P. Borck, Esq.,** Assistant Editor - **Angelica Velez,** Design Editor



CSK'S PRIDE PROGRAM

How to quickly and efficiently close your files by adhering to a proven formula for quick claim resolution. This will entail a full explanation of CSK's cutting edge program to close litigated files quickly and effectively.

INITIAL BREAKOUT SESSION

1. **REDUCING PAST MEDICALS** – How to devastate your opponent's case by impacting his ability to board past medicals.

2. **WHAT'S TRENDING IN PIP** – A comprehensive update on all developing trends in PIP law. This will include discussion of AOB's, pricing, and recent case law impacting PIP.

3. **CONDO CLAIMS – TRUTH IS STRANGER THAN FICTION** – Real-life stories that simply cannot be believed.

4. **FLORIDA BAD FAITH UPDATE – "THE DANGER STILL LURKS."** – Comprehensive update on the current state of bad faith law in Florida. This will include instruction on the most recent set-up tactics being utilized by the plaintiff's bar to uncap limits.

5. **THE TRIGGER OF COVERAGE IN PROPERTY DAMAGE CLAIMS** – Few areas of the law are as confused as the proper trigger of coverage in property damage and construction claims. This session will focus on identifying the proper trigger of coverage and the application of the statute of limitations.

6. **CLASS ACTIONS – WHY YOU NEED TO BE READY FOR THIS EMERGING TREND** – In this session a CSK expert in class action litigation will discuss how these claims are now being routinely filed in the insurance and liability context. The discussion will focus on emerging trends and danger areas on the frontline of class action litigation. The claims professional will also be instructed on effective tools for handling this type of litigation.

BREAKOUT SESSION NO. 2

1. **PROPOSALS FOR SETTLEMENT** – A primer on when and how to use a PFS to put pressure on the Plaintiff. The enforceability of the PFS has become a legal minefield. Instruction will be provided to assure that your Proposal withstands judicial review.

2. **AVOIDING THE MORASS – HOW TO EXTRICATE YOUR INSURED FROM CONSTRUCTION DEFECT CLAIMS QUICKLY** – Construction defect claims can last for years and prove extremely costly. This is true even if you are a "bit player" in a much larger case. This session will explore options to quickly extricate your insured from the multi-party construction nightmare.

3. **CHALLENGING THE ASSIGNMENT OF BENEFITS – LET'S GET OFFENSIVE** – This seminar will explore effective ways to challenge first party property, glass claims and PIP matters.

4. **NURSING HOME LITIGATION – IS THE DANGER OVER?** – In this session a recognized CSK expert in nursing home litigation will discuss the current state of the law and emerging trends in these types of cases. Focus will be on the types of claims currently being pursued and how to effectively and quickly handle same.

5. **TARGET ON THE PROFESSIONAL – WHY NON-MEDICAL PROFESSIONALS ARE IN INCREASING DANGER** – Professionals of all types including lawyers, engineers, insurance agents and directors and officers are increasingly becoming the target of litigation. This session will explore these trends and provide methods to aggressively, effectively and manage this litigation.

6. **HOW TO TURN YOUR PIP DEPARTMENT INTO A LEAN MEAN FIGHTING FORCE** – A leading CSK expert in PIP litigation will discuss how to effectively structure and handle PIP claims so that the company can take the fight to the plaintiff's bar.

BREAKOUT SESSION NO. 3

1. **IME REPORTS – WHY YOU SHOULDN'T TAKE THEM FOR GRANTED** – IME reports are too often generic and ineffective. This session will focus on how to interact with your IME physician to make sure that you are provided with a well-structured report that you can effectively use in litigation. The discussion will also include how to effectively present your IME physician at deposition and trial.

2. **WINNING THE SLIP AND FALL CASE – WHY PRO-ACTIVE EARLY HANDLING MATTERS** – This session will focus on slip and fall cases in the commercial setting and will instruct the claims professional on pro-active tools to effectively handle these cases.

3. **STUART V. HERTZ – SUBSEQUENT MEDICAL PROVIDERS – AM I STILL RESPONSIBLE FOR THE NEGLIGENCE OF OTHERS** – This session will update the claims professional on the rules relating to the responsibility of the initial tortfeasor for the subsequent negligence of others and how such negligence can impact your claim and the result achieved.

4. **HOW TO EFFECTIVELY HANDLE DIFFICULT CLAIMS** – In this session the claims professional will be instructed on how to recognize problem claims early on. These types of claims often involve multiple insureds, multiple claimants, time limit demands or coverage issues. The claims professional will be instructed on effective means to handle these claims to a successful conclusion.

5. **INDEMNITY/ADDITIONAL INSUREDS AND THE INSURED CONTRACT** – Before you can successfully formulate a defense strategy you need to know who is covered under the policy and for what. This session will focus on tips for identifying additional insureds and properly determining the scope of coverage.

BREAKOUT SESSION NO. 4

1. **JUMP STARTING YOUR FILES – HOW TO MOVE STALLED CLAIMS TO CONCLUSION** – This session will explore methods of "shocking" stalled files back to life and moving them forward to conclusion. An old file is an expensive file and delays often lead to bad results. This session will explain CSK's formula for re-energizing cases and moving them towards resolution.

2. **THE NEW LATE NOTICE – IN THE PROPERTY DAMAGE CONTEXT** – This session will explore late notice in the property context and how to properly apply it to presented claims.

3. **SUCCESSFULLY DEFENDING THE REAR-END COLLISION** – Instruction on how to effectively defend the rear-end collision case through the effective use of multi-disciplinary expert witness testimony.

4. **EMPLOYMENT LAW** – Avoiding the pitfalls of litigation, getting these matters settled and the art of trying an employment case.

5. **NEGLIGENT SECURITY CASES – WHY DANGER LURKS FOR THE UNPREPARED** – Negligent security cases are filed in many contexts. This session will discuss why all such claims present potential danger and will discuss and evaluate the latest tools available to the claims professional for effective and pro-active handling.

6. **THE McCALL DECISION – NON ECONOMIC DAMAGES IN THE MEDICAL MALPRACTICE WRONGFUL DEATH CONTEXT – WHERE DO WE GO FROM HERE** – This session will discuss the Florida Supreme Court's decision in Estate of McCall v. U.S, and the defense of non-economic damage claims in medical malpractice wrongful death claims.

BREAKOUT SESSION NO. 5

- **CSK'S PRIDE PROGRAM** – How to quickly and efficiently close your files by adhering to a proven formula for quick claim resolution. This will entail a full explanation of CSK's cutting edge program to close litigated files quickly and effectively.

- **FLORIDA WORKERS' COMPENSATION 101** – This session will provide the claims professional with an overview of the history of Florida workers' compensation, the current workers' compensation system and potential changes that may arise in the near future.

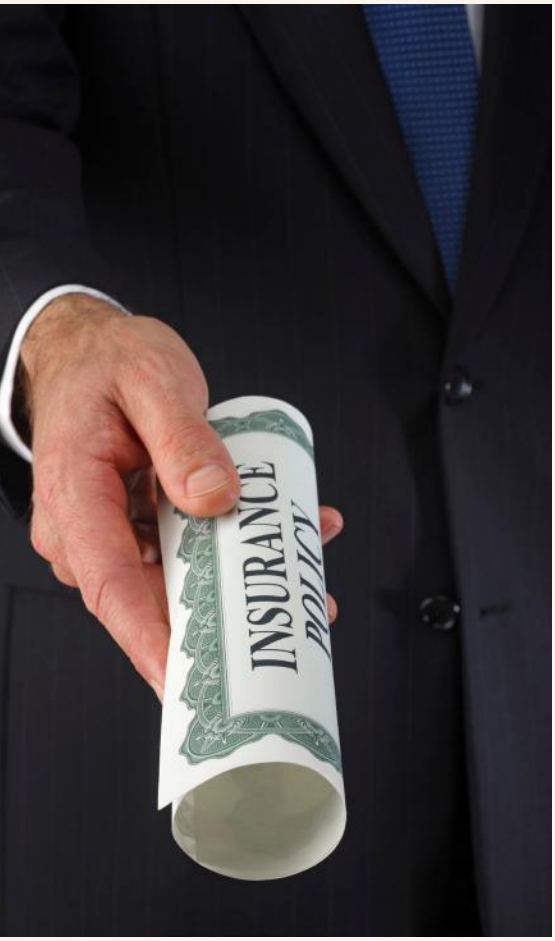
- **FLORIDA WORKERS' COMPENSATION CASE LAW UPDATE** – This session will discuss and analyze recent case law that has impacted the workers' compensation system. The purpose of this session is to bring the claim professional up to speed on the current trends affecting workers' compensation as well as to provide a look into the cases on the horizon.

- **FLORIDA WORKERS' COMPENSATION HOT TOPICS** – The Hot Topics session will review the current issues that occur during the course of workers' compensation litigation in the context of Employer immunity, including estoppel and waiver of the immunity defense, which impact the claims exposure for the Carrier/TPA and liability for non-workers' compensation matters for the Employer. Topics include the affirmative defense of Fraud/Misrepresentation and will explore the remedies available to claim professionals in the proper handling of such matters from a legal perspective. Guest speaker, Jeff Sweat owner of SIU Central, will speak on Fraud/Misrepresentation from an investigative perspective.

Insurance Brokers, Agents and Dual Agents:

How to Avoid Being Bound

Daniel Duello, Esq.



It is important for insurers issuing policies in the state of Florida to understand the distinctions between an independent broker and a captive agent for an insurer. The distinction between an insurance agent and an insurance broker is important because the acts and knowledge of an agent are imputable to the insurer, while the acts and knowledge of a broker or independent agent are imputable to the insured. *Essex Ins. Co. v. Zota*, 985 So. 2d 1036 (Fla. 2008). It is also important to recognize that in certain instances an independent broker can be legally classified as a "dual agent."

The distinction between agents and brokers can have a profound impact on insurance litigation, especially in situations where the insurer seeks rescission of the policy based on an insured's material misrepresentations made on the application for insurance.[1] An insurer will be estopped from rescinding a policy if it had knowledge of the misrepresentation and still chose to issue the policy or if it obtained knowledge of the misrepresentation and continued accepting the insured's payment of premiums. *See Johnson v. Life Ins. Co. of Ga.*, 52 So. 2d 813, 815 (Fla. 1951).

The purpose of this article is to address the importance of the insurance "broker" versus "agent" distinction, explain situations where an independent insurance broker can be legally transformed into a "dual agent" for both the insured and the insurer, and suggest practical steps insurers can take to mitigate the risk of being legally bound by the actions of an independent insurance broker.

Prior to examining the broker versus agent classification, it is helpful to consider the following example:

Insurance Annie lives next door to Tom. Tom, while on a walk with Annie, finds a skittish malnourished Rottweiler wandering the neighborhood. Unable to locate the owner, Tom begins to nurse the emaciated dog back to health. Tom once again approaches Annie to procure a new homeowner's policy. During the application process, Tom instructs Annie to answer "no" to a question asking if there are any Rottweilers living in the household, because Tom intends on taking the dog to an animal shelter to be adopted.

After the new homeowner's policy is bound, but before Tom can find a new home for the dog, Tom's pest control company sends an employee to Tom's house for its yearly treatment. The pest control employee enters an upstairs bedroom where the dog is sleeping and begins to spray the room. The dog attacks the employee. By the time Tom gets to the dog's room, the dog has inflicted serious injuries upon the employee. The employee sues Tom. Faced with the possibility of a high exposure claim, Tom's insurer files a declaratory action seeking a determination entitling them to rescind the policy based on Tom's failure to disclose the dog on his insurance application.

Whether or not the insurer will be able to rescind the policy will likely turn on whether Insurance Annie is classified as an independent insurance broker or as an agent for the insurer.

Insurance "Agent" vs. Insurance "Broker" and the Imputation of Acts and Knowledge

Under Florida law, insurance agents represent the insurers that appoint them and brokers represent the customer whom purchases the insurance. An "insurance broker" solicits insurance orders from the general public and is not bound by a con-

tract to work for or solicit insurance for any particular insurance company. *Amstar Ins. Co. v. Cadet*, 862 So. 2d 736 (Fla. 5th DCA 2003).

One legal treatise explains the broker and agent distinction as follows:

> A broker is, in essence, employed in each instance as a special agent for a single purpose, while the very definition of agent indicates an ongoing and continuous relationship. Since many insureds deal with the same broker for long periods of time, it is, in most cases, the continuity of the agency relationship that differs from the broker relationship; brokers and insureds are ordinarily involved in what can be viewed as a series of discrete transactions, while agents and insurers tend to be under some duty to each other during the entire length of the relationship.

3 Lee R. Russ, *Couch on Insurance 3d*, § 45:1 (1997) (footnotes omitted).

The Florida Supreme Court held that an independent insurance broker is presumed to have acted on the insured's behalf for purposes of obtaining insurance coverage. *Zota*, 985 So. 2d at 1047-48.

Thus, in our example above, whether Insurance Annie is Tom's broker or the insurer's agent will determine whether Annie's knowledge of the dog is imputed to Tom or to the insurer. If Annie's knowledge of the dog is imputed to the insurer, the insurer will likely be estopped from rescinding the policy based on Tom's failure to disclose the dog.

For example, if Annie's business is named Annie's Independent Insurance Brokerage Shop and the Independent Brokerage Agreement entered into between Annie and the insurer states Annie is not an agent of the insurer and has no authority to commit the insurer to any course of action without first obtaining the prior written permission from the insurer, it would appear clear that Annie was not the insurer's agent.[2] Therefore, any knowledge Annie has regarding the dog would be imputed to Tom and not the insurer.

However, even with the Independent Brokerage Agreement and Tom's prior business dealings with Annie, Tom's counsel could attempt to establish that Annie was a "dual agent" of both Tom and the insurer.

Dual Agency via Apparent Agency and Statutory Agency

Under certain well defined circumstances, an insurance broker may act in a dual capacity, performing certain acts for both the insured and the insurer. *Almerico v. RLI Ins. Co*., 716 So. 2d 774 (Fla. 1998). In *Almerico*, the Florida Supreme Court held that "under the provisions of section 626.342(2) . . . as well as Florida's common law, civil liability may be imposed upon insurers who cloak unaffiliated insurance agents with sufficient indicia of agency to induce a reasonable person to conclude that there is an actual agency relationship." *Id*. at 783.

To prove that Annie was a dual agent during the application process, Tom needs to establish that Annie was the apparent or statutory agent of the insurer. If established, Annie's knowledge of the dog will be imputed to the insurer. As a result, the insurer will be estopped from rescinding the policy based on the failure to disclose the dog.

Apparent Agency

In order to establish the existence of apparent agency, there must be a determination of the following: 1) there was a representation by the principal that the agent was authorized to act on its behalf; 2) the injured party relied on that representation; and, 3) the injured party changed position in reliance upon the representation and suffered detriment. *Amstar Ins. Co. v. Cadet*, 862 So. 2d 736, 742 (Fla. 5th DCA 2003).

In our example, suppose that the insurer had placed advertisements in the local newspaper containing its logo and a picture of Annie with the caption, "Need an affordable homeowner's policy? Come in and speak with Annie to obtain a quote!" If Tom establishes that he relied on the newspaper article and thought Annie was authorized by the insurer to provide quotes and obtain coverage, he will likely be successful on his claim that Annie was the insurer's apparent agent and her knowledge of the dog should be imputed onto the insurer.

Statutory Agency

Even without something as obvious as the advertisement mentioned above, the insurer could still be bound by Annie's knowledge under more innocuous circumstances. For example, assume that Tom made his misrepresentation on an insurance application bearing the insurer's logo and that the insurer provided Annie with the insurance application.

Section 626.342, Florida Statutes provides as follows:

> (1) An insurer, . . . may not furnish to an agent *any blank forms, applications, stationery, or other supplies to be used in soliciting, negotiating, or effecting contracts of insurance on its behalf* unless such blank forms, applications, stationery, or other supplies relate to a class of business for which the agent is licensed and appointed, whether for that insurer or another insurer.
>
> (2) An insurer, . . . who furnishes any of the supplies specified in subsection (1) to

> an agent . . . and who accepts . . . any insurance business for such agent. . is subject to civil liability to an insured. . . to the same extent and manner as if such agent. . . had been . . . authorized by the insurer to act on its behalf.

Fla. Stat. §626.342(1)-2 (emphasis added).

In *Almerico*¸ the Supreme Court of Florida observed "[s]ection 626.342(2) appears to be an insurance consumer law designed to protect insurance consumers when dealing with insurance companies through brokers and agents." 716 So. 2d at 782. The Court held that an insurer may be held accountable for those brokers it cloaks with "sufficient indicia of agency to induce a reasonable person to conclude that there is an actual agency relationship." *Id*. at 783. Evidence of "indicia of agency" can be shown if the insurer furnished the agent with blank forms, applications, stationery, or other supplies used in soliciting or negotiating insurance contracts. *Id*. at 777.

The *Almerico* opinion seemingly still requires that the insured actually rely on the "blank forms, applications, stationary, or other supplies to be used in soliciting, negotiating, or effectuating contracts for insurance on its behalf." *Id*. at 783 For instance, if the broker received materials from an insurer and threw them in the trash, imputing the actions of the broker against the insurance company could serve the purpose to threaten the continued existence of independent brokers by constantly imputing their actions against to insurers.

However, plaintiffs' lawyers have argued an insured's actual reliance is not required to establish statutory agency and all that is required is: 1) the insurer furnish to an insurance broker blank forms, applications, stationary, or other supplies: and, 2) the insurer accept business from the insurance broker. *See Straw v. Associated Doctors Health and Life,* 728 So. 2d 354 (Fla. 5th DCA 1999) (concluding that the trial court erred by removing the issue of agency from the jury where the insurer provided the appellant with blank applications, training materials, and accepted the business generated therefrom).

Under a plaintiffs reading of *Almerico*, Tom will be able to argue that Annie was the insurer's statutory agent, merely because the insurer provided Annie with the insurance application, which bore the insurer's logo, and the insurer accepted business from Annie. 716 So. 2d at 774. This would seem to all but eliminate the insurance broker versus agent distinction; however, there are steps an insurer can take to protect themselves from being held responsible for the actions of an independent insurance broker.

Placing a Potential Insured on Notice or Inquiry Notice of a Broker's Lack of Actual Authority

When accepting business from an independent insurance broker, an insurer can take steps to notify the applicant of the limitations on an insurance broker's actual authority or place the insured on inquiry notice of the broker's lack of actual authority. The insurer in our example could have prevented Tom's imputation of knowledge argument had it placed Tom on notice or inquiry notice of Annie's lack of actual authority.

"[T]he principal (insurer) will not be bound by the agent's action if the insured knew or was put on notice of inquiry as to the limitation on the agent's actual authority." *Citizens Prop. Ins. Corp. v. European Woodcraft & Mica Design, Inc*., 49 So. 3d 774, 777 (Fla. 4th DCA 2010). "In order to charge a person with notice of a fact of which he might have learned by inquiry, the circumstances known to him must be such as should reasonably suggest inquiry and lead him to inquiry." *Sheres v. Genender*, 965 So. 2d 1268, 1271 (Fla. 4th DCA 2007) (*quoting Chatlos v. McPherson*, 95 So. 2d 506, 509 (Fla.1957)).

Florida courts have held that if the written application states that the agent or broker cannot bind the policy, the insured is put on sufficient notice that the agent or broker is not the actual or statutory agent of the insurer. An agent cannot bind an insurer by contracting to issue a policy "when the written application expressly states that the agent cannot so contract." *Murphy v. John Hancock Mut. Life Ins. Co*., 213 So. 2d 275, 276 (Fla. 3d DCA 1968).

The following are examples of language included on an insurance application that Florida courts have found sufficient to put the insured on notice of a broker or agent's lack of actual authority:

> The Agent has no authority to bind the company without first obtaining confirmation from the company through a telephonic binder and receiving a corresponding binder number. The agent has no right to make, alter, modify or discharge any contract or policy issued on the basis of this application. *Amstar Ins. Co. v. Cadet*, 862 So. 2d 736, 741 (Fla. 5th DCA 2003).

> Effective Date of Coverage is upon approval of [Insurer]. No insurance agent has the power to bind coverage or make the policy effective. Receipt by agents of premiums is not receipt by [Insurer] and does not make the policy effective. Applicants must not rely on representations of any party other than [the Insurer]. *Citizens Prop. Ins. Corp. v. European Woodcraft & Mica Design, Inc*., 49 So. 3d 774, 777 (Fla. 4th DCA 2010).

> The Agent shall have no authority on behalf of the Company to make, alter or discharge any contract or any of

the terms, rates or conditions of the Company's policies or contracts; nor to waive the performance of any of the terms or conditions of any policy or other contract to which the Company is a party; nor to bind the Company on account of any indebtedness; nor to bring or defend any suit involving the Company; nor to receive any money payable to the Company except (1) for the first premium on applications for insurance obtained by him and for (2) such premiums as he may be specifically authorized to collect . . . The Company shall at all times have the right to reject, cancel or postpone any application for insurance without specifying the reason therefore . . . *Steele v. Jackson Nat. Life Ins. Co*., 691 So. 2d 525, 527 (Fla. 5th DCA 1997).

> No agent shall have the right to make, alter, modify, or discharge any contract or policy issued on the basis of this application. . . *See Almerico v. RLI Ins. Co*., 716 So. 2d 774,781 (Fla. 1998) (*quoting Brown v. Inter-Ocean Ins. Co*., 438 F. Supp. 951, 954 (N.D. Ga. 1977) (applying Florida law)).

A signed application containing similar limiting language may establish that the insured knew the broker lacked actual authority to bind the insurer.

Insurers that have online application systems that do not require an applicant's signature should take steps to demonstrate that any potential insured was put on inquiry notice of the broker's lack of actual authority. In order to demonstrate inquiry notice, insurers could include similar language on any forms, applications, stationery, or other supplies to be used by an insurance broker in soliciting, negotiating, or effecting contracts of insurance. This will help ensure that a court will not impute the actions of an insurance broker against an insurer.

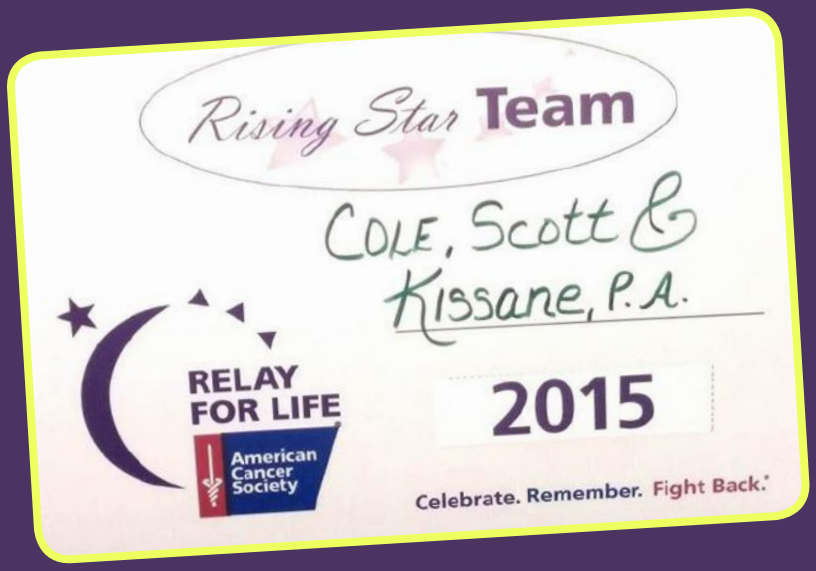
Insurers may never be able to eliminate all uncertainties posed when accepting business from independent insurance brokers; however, by taking the steps listed above, insurers can significantly reduce the risk of having the actions of independent brokers imputed to them.

(Endnotes)

1 Fla. Stat. §627.409, states that a misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the contract or policy if the misrepresentation, omission, concealment, or statement is material either to the acceptance of the risk or to the hazard assumed by the insurer. *Kieser v. Old Line Life Ins. Co. Of Am*., 712 So.2d 1261 (Fla. 1st DCA 1998).

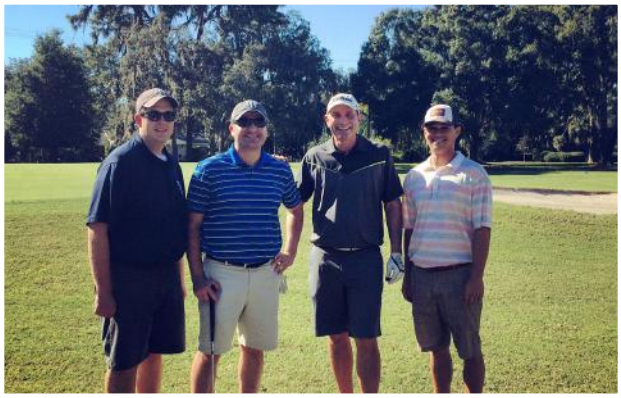
2 The essential elements necessary to establish an actual agency relationship are (1) acknowledgment by the principal that the agent will act for him, (2) acceptance by the agent of the undertaking, and (3) control by the principal over the agent's actions. *Villazon v. Prudential Health Care Plan, Inc*., 843 So. 2d 842 (Fla.2003).

RISING STAR TEAM

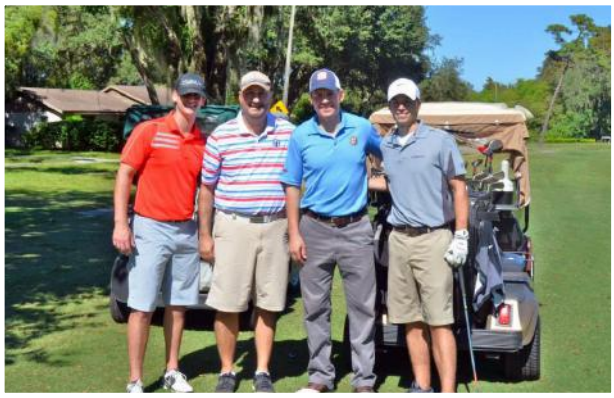


CSK's Pensacola Office Relay for Life Team was recognized by the American Cancer Society as one of the top teams in terms of donations, raising over $5,000 to date. The CSK team is in the top three out of 26 teams and over 100 participants.

HILLSBOROUGH COUNTY BAR ASSOCIATION



CSK Attorneys from left to right, Chris Donegan, Justin Saar, Dan Shapiro and Kevin Leung, a member of CSK's office services.

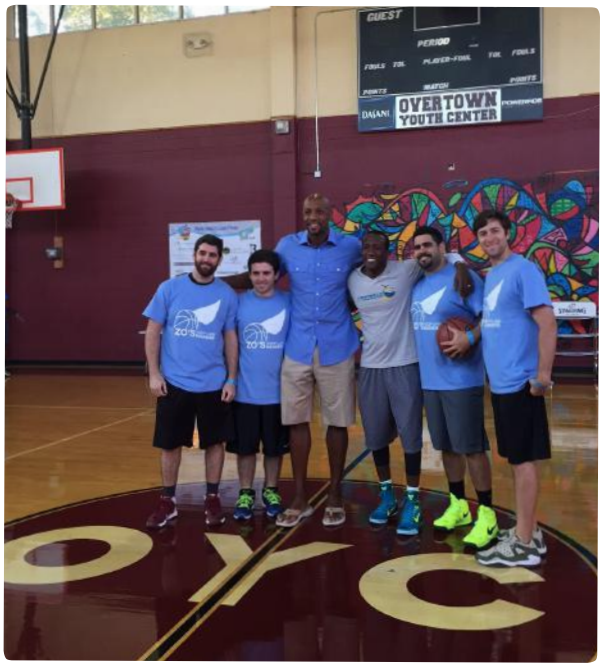


CSK Attorneys from left to right, Hal Weitzenfeld, Aram Megerian, Geoffrey Schuessler and Robert Hubbard.

CSK's Tampa office participated in Hillsborough County Bar Association's Golf Tournament. The Hillsborough County Bar Association is one of the largest voluntary bar associations in Florida and has earned a national reputation for its outstanding programs and events such as this. The golf tournament is a long standing tradition that is attended by lawyers, judges, staff members, and anyone interested in supporting the Hillsborough County Bar Association in its efforts to better serve the community.

CSK'S BASKETBALL TEAM

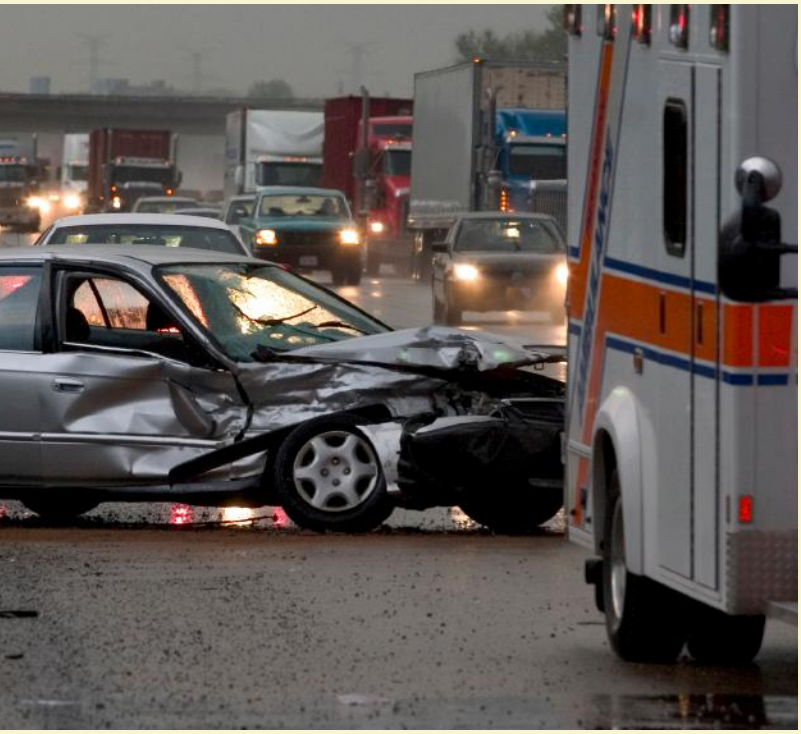
Attorneys from CSK's Miami Office participated in Alonzo Mournings' Hoop-Law Madness charity basketball tournament at the Overtown Youth Center. The Center provides services that foster hope and promotes life-long learning and success for inner-city youth. This tournament was a testament to the commitment of South Florida's legal community to make a difference for students in the Overtown community and surrounding areas who have the opportunity to receive services from the Overtown Youth Center.



CSK Attorneys from left to right, Alejandro Cura, Brian Dominguez, David Caballero and Andrew Freedman.

How the Concept of Emergency Medical Conditions Is Changing the Florida No-Fault Personal Injury Protection Landscape

 Ian S. Horowitz, Esq. &  Tierney N. Conklin, Esq.



Legislative Intent of Adding the Emergency Medical Condition Limitation

Since its inception in 1971, medical providers and insurers have litigated many aspects of §627.736 also known as Florida's No-Fault Personal Injury law. But one area of this law has always been constant: if coverage does indeed exist, the insured is entitled to $10,000 in personal injury protection ("PIP") benefits. On January 1, 2013, for the first time, this changed.

Fraud and abuse in no-fault vehicle insurance has led to significant increases in PIP premiums and has made the coverage unaffordable for an increasing number of Floridians.[1] By retaining the maximum $10,000 for emergency medical conditions ("EMC"), and limiting reimbursement for non-emergent injuries, the intent was to reduce cost drivers in the PIP system and was expected to have a positive fiscal impact on policyholders.[2]

Amendment to Florida Statute §627.736

Effective January 1, 2013, an injured person *must* seek medical care within fourteen days after a motor vehicle accident to be eligible for PIP benefits. [3] Furthermore, the new PIP statute provides:

> 3. reimbursement for services and care provided in subparagraph 1 or subparagraph 2 up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464 has determined that the injured person had an **emergency medical condition**.
>
> 4. Reimbursement for services and care provided in subparagraph 1 or subparagraph 2 is limited to $2,500 if a provider listed in subparagraph 1 or subparagraph 2 determines that the injured person did not have an emergency medical condition.[4]

EMC Defined

Florida Statute §627.732(16), as well as Florida Statute §395.002(8) define an EMC as follows:

> a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) serious jeopardy to patient health, (b) serious impairment to bodily functions, [or] (c) serious dysfunction

> of any bodily organ or part.[5]

Although the Florida Legislature defined an EMC, its definition is still subjective, and as a result, the medical provider has significant discretion in determining the existence of an EMC.

The definition above is almost identical to the definition of an EMC provided in The Emergency Medical Treatment and Labor Act ("EMTALA"), a federal law which requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay, which states in part:

> a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.[6]

This definition has been further interpreted to include instances where a patient, immediately after a stroke, suffered an EMC since she was "in imminent danger of death or serious disability."[7] Additionally, a hospital was not liable under EMTALA when it discharged a patient after determining that there was not an emergency medical condition, where the patient only suffered from muscle spasms.[8]

Determinations of EMCs have also been the subject of litigation in other areas of law, such as in the Worker's Compensation arena. In 2013, Florida's First District Court of Appeal determined the existence of an EMC where a patient's symptoms included a massive herniated disc, associated weakness and numbness, an inability to move or stand, and "unbearable pain" which, if left alone, could have caused serious jeopardy to the patient's health, such as cauda *equina syndrome*.[9]

Notwithstanding the foregoing interpretations, the EMC determinations made in the PIP arena are oftentimes only due to soft tissue injuries which do not come close to the severity level of the conditions described above.

Who Determines the Existence of an EMC?

With the exception of a recent opinion by county court Judge Michaelle Gonzalez-Paulson, courts in Florida have stated on numerous occasions that EMC benefits are only available where a determination of an EMC has been provided to the insurer by a statutorily authorized medical provider.[10] The statute defines two groups of defined "medical providers". The first group includes medical doctors, doctors of osteopathy, dentists, physician assistants, and nurse practitioners.[11] The second group includes chiropractors.[12]

The distinction between the two groups is relevant because only the physicians listed in the first group can make a determination that an EMC exists, extending the amount of available PIP benefits to $10,000.00.[13] However, the physicians listed in the second group can only make a determination that a condition is *not* an EMC limiting PIP benefits to $2,500.00.[14] The practical effect of this is to remove the ability of chiropractors to unilaterally attain access to an insured's $10,000.00 in PIP benefits without obtaining the determination of an EMC by a medical provider defined in group one.[15]

As such, although chiropractors are authorized to provide treatment to PIP insureds, they *cannot* make the determination that a patient has suffered an EMC.[16] Rather, the statute only allows for chiropractors to make a determination that an EMC does *not* exist.[17] However, the constitutionality of this provision of the statute was recently challenged in *Garrido D.C., P.A. v. Progressive,* whereupon County Court Judge Michaelle Gonzalez-Paulson ruled that the exclusion of chiropractors from being able make an EMC determination is unconstitutional as applied and violates the equal protection and due process clause of the Florida Constitution.[18]

Additionally, it is important to note that Florida courts have also interpreted the statute to define a "provider" as one who has actually provided services or care to the patient.[19] As such, although a medical provider may perform an Independent Medical Examination for the Insurer, that same provider is not classified as a provider as defined by the Statute and thus cannot make a determination regarding EMC since he or she did not treat the patient.[20]

Effect of EMC Determination on Amount of PIP Benefits Available

If an EMC determination is made, $10,000.00 in PIP benefits become available; however, if no determination has been made either way, PIP benefits are limited to $2,500.00.[21]

Although Florida Courts have agreed there is no default provision in absence of an EMC determination, the courts have established that when a qualified medical provider does not diagnose an individual with an EMC, the benefits available are limited to $2,500.[22] As such, while there is no "default provision" *per se*, there is an affirmative duty placed on the physician to make an EMC determination, and without this, coverage is limited to $2,500.00.

Additionally, an insurer does not confess judgment if it receives

an EMC declaration after suit has been filed and it expands policy limits to $10,000.00.[23]

Consistent with the line of reasoning discussed above, a trial court in the 15th Judicial Circuit granted a defendant's motion for summary judgment and held that the defendant properly limited PIP benefits to $2,500.00 absent an EMC determination.[24] Although the majority of Florida's lower courts have held the same, upon request of plaintiff's counsel after the court's ruling, the trial court certified the following question to the Fourth District Court of Appeal on October 21, 2014:

> In an action for an assignee for no-fault insurance benefits under a policy of motor vehicle insurance, are benefits above $2,500 only available where there has been a certification by a medical provider authorized by statute that an emergency medical condition exists, as defined in the Florida no-fault law?[25]

While the plain reading of the statute seems clear on this issue and the lower courts[26] have ruled consistently to uphold that plain meaning, the same issue is also currently on appeal in the United States Court of Appeals for the Eleventh Circuit.[27]

Challenging an EMC Determination

As stated above, once an authorized medical provider[28] determines the existence of an EMC, the insurer cannot retain another authorized medical provider to challenge that determination (i.e. an Independent Medical Examination).[29] In fact, there is no express mechanism in the statute allowing an insurer to challenge an EMC determination.[30] A trial court in the 17th Judicial Circuit stated, "if the legislature wanted an insurer to have the ability to challenge a treating provider's determination of an EMC, it would have expressly provided for this provision in the Statute."[31] That said, an insurer still has the right, at any time, to challenge the medical necessity, reasonableness of price, and whether the treatment was related to the crash.[32]

Future of EMCs

In 2015, the Florida Office of Insurance Regulation released a report indicating that the growth of fraud in PIP claims has halted significantly.[33] While this report would seem to buttress the legislative intent in curbing fraud, especially in the Miami and Tampa areas, the determination of EMCs still remains the center of much litigation and consternation.[34]

Based on the report, which was required to monitor how the statutory changes affected overall insurance costs, the average medical cost paid through PIP claims has dropped 14% between 2011 and 2015 with the average payment down 28.7% in south Florida in the same time.[35]

That said, this data is only in the preliminary stages, and is still premature to determine the full and actual effect of the changes in the law. Many still believe the law will be challenged and amended yet another time.[36]

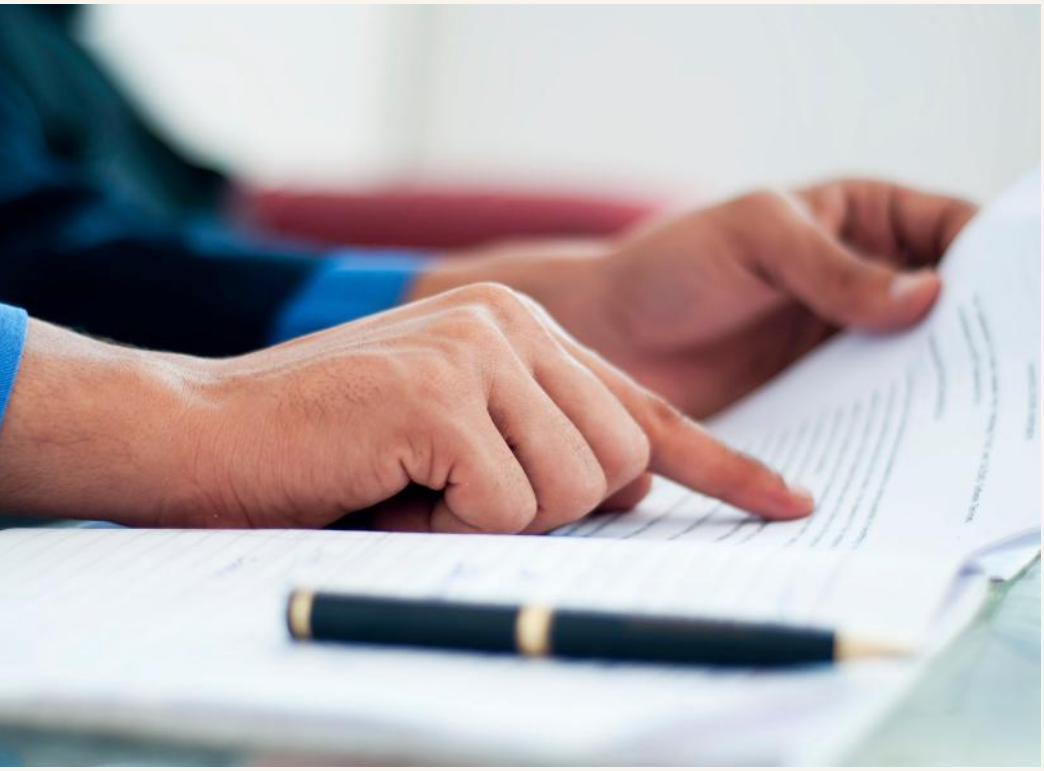
(Endnotes)

1 *House of Representatives Staff Analysis to Bill HB 119.*
2 *Id*.
3 Fla. Stat. §627.736(1) (a) (3) (2013).
4 *Id*.
5 Fla. Stat. §627.732(16) (2013). *See also* Fla. Stat. §395.002 8) (2012).
6 Emergency Medical Treatment and Labor Act of 2011 § 42 U.S.C.A. § 1395dd (e).
7 *Thornton v. Sw. Detroit Hosp*., 895 F.2d 1131, 1134 (6th Cir. 1990).
8 *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1140 (8th Cir. 1996)
9 *Cespedes v. Yellow Transp., Inc*. (URC)/Gallagher Bassett Services, Inc., 130 So. 3d 243, 254 (Fla. 1st DCA 2013); Cauda equina syndrome is a rare disorder that usually is a surgical emergency.
10 *Enivert v. Progressive Select Ins. Co*., Case No. 14-CV-80279 (S.D. Fla. July 23, 2014).
11 Fla. Stat. §627.736(1)-(2) (2013).
12 *Id.*
13 *Id*.
14 *Id*.
15 *Id*.
16 *McCarty v. Myers*, 125 So. 3d 333, 335 (Fla. 1st DCA 2013).
17 Fla. Stat. §627.736(1)(a)(4)
18 *See* unpublished "Order Granting Plaintiff's Motion for Final Summary Judgment; Final Declaratory Judgment Thereon and Certified Question of Great Public Importance" in case No. 13-4491 CC 26 (3).
19 *First Choice Chiropractic & Rehabilitation Center, Inc., v. Progressive Ins. Co*., 22 Fla. L. Weekly Supp. 617a.
20 *Id*.
21 Fla. Stat. §627.736(1) (a) (3).
22 *First Choice Chiropractic & Rehabilitation Center, Inc., v. Progressive Ins. Co*., 22 Fla. L. Weekly Supp. 617a. *See also Enivert v. Progressive Select Ins. Co*., Case No. 14-CV-80279 (S.D. Fla. July 23, 2014); *Garrido, D.C., P.A. v. Progressive American Ins. Co*., 22 Fla. L. Weekly Supp. 446a (2015).
23 *Doc Tony Westside Chiro., LLC., v. United Services Auto. Assoc.,* 22 Fla. L. Weekly Supp. 640a.
24 *L. Lee Smith, D.C., P.A., vs. USAA Casualty Ins. Co*., 22 Fla. L. Weekly Supp. 445a.
25 *Id*.
26 *See First Choice Chiropractic & Rehabilitation Center, Inc., vs. Progressive Ins. Co*., 22 Fla. L. Weekly Supp. 617a. *See also Enivert v. Progressive Select Ins. Co*., Case No. 14-CV-80279 (S.D. Fla. July 23, 2014); *Garrido, D.C., P.A. v. Progressive American Ins. Co.*, 22 Fla. L. Weekly Supp. 446a (2015).
27 *See Glenaan Robins v. Garrison Property and Casualty Insurance Company*, Case No. 14-13724-AAL.T. and *Sendy Enivert v. Progressive Select Insurance Co.*, Case No. 14-13725-BBL.T. (Consolidated).
28 Fla. Stat. §627.736(1) (a) (1).
29 *Dr. Craig Selinger, D.C., P.A., v. Enterprise Leasing Company of Florida, LLC*, 22 Fla.L. Weekly Supp. 163a.
30 Fla. Stat. §627.736(4) (b) and §627.736(7) (a).
31 *Dr. Craig Selinger, D.C*., P.A., at 22 Fla.L. Weekly Supp. 163a.
32 Fla. Stat. §627.736(4) (b) and Fla. Stat. §627.736(7) (a).
33 *Report on Review of the Data Call Pursuant to HB 119-January 1, 2015.*
34 *Id*.
35 *Id.*
36 Jim Turner, *PIP Insurance Could Continue To Get Green Light*, Sun Sentinel, January 7, 2015

Fighting Back:

What Are Letters of Protection? Why Are They Important? And How Do You Use Them To Attack The Reported Medical Charges And Illustrate The Financial Bias Between Treating Physicians and Opposing Counsel?

Christopher Donegan, Esq.



Imagine a plaintiff claimed six-figures in past medical damages allegedly related to the accident involving your insured. The plaintiff's treatment was almost exclusively provided under Letters of Protection ("LOPs") and the bills submitted are higher than bills submitted by other providers accepting major health insurance. The question you may be asking yourself is: "What tools are available under Florida law to help challenge these medical bills?" The purpose of this article is to explain the new trend in Florida law that answers this question.

In order to attack a plaintiff's medical damages, understanding the fundamental elements of personal injury damages and medical expenses is imperative. Florida's standard jury instruction 501.1 instructs when a jury will consider awarding damages: "If your verdict is for the Defendant, you will not consider the matter of damages. But if the greater weight of the evidence supports the Plaintiff's claim, you should determine and write on the verdict form, in dollars, the total amount of money that the greater weight of the evidence shows will fairly and adequately compensate the Plaintiff for the following elements of damage, including damage that the Plaintiff is reasonably certain to incur in the future.[1]

Florida's standard jury instruction 501.2 goes on to discuss the elements that make up personal injury damages, including how to calculate medical expenses. Specifically, Florida standard jury instruction 501.2 states that "The care and treatment of the claimant is the reasonable value or expense of hospitalization and medical and nursing care and treatment necessarily or reasonably obtained by Plaintiff in the past or to be so obtained in the future."[2] The jury is asked to evaluate the "reasonable value" of damages being claimed. Therefore, the defense focuses on showing how the charges being submitted are not reasonable.

There are a few conventional methods to challenge medical damages. One method is to argue the amount submitted by the plaintiff is excessive when compared to charges for similar procedures being submitted by other providers in the medical community. Another method is to address any jury award post-verdict by arguing set-offs. The typical set-offs argued are the Personal Injury Protection Benefit Set-off[3] (for some motor vehicle cases) and contractual adjustments.[4] Based on recent case law, discussed below, the defense has a new method available to challenge the medical damages being claimed. The defense can now illustrate to the jury the financial bias treating providers have in defending their bills and their motivation for injecting themselves as an advocate for the plaintiff. This is done by showing the jury that the provider is waiting to be paid until the conclusion of the lawsuit pursuant to a Letter of Protection ("LOP").

An LOP is an agreement between the treating provider and plaintiff stating payment will be made from the monies collected at the conclusion of the litigation. The existence of an LOP suggests that the provider has no guarantee of payment and that the plaintiff may not have the resources to reimburse the provider. Therefore, when reviewing medical records, make sure an LOP is not overlooked. It is important to note that many treating providers are no longer labeling or titling these agreements as a "Letter of Protection." Our firm has seen LOPs appear in medical records as just the abbreviation LOP or L.O.P. and titled as an "Individual Patient Payment Plan" or "Provider Contract."

The landmark case which brings LOPs to the forefront when challenging a treating provider's financial bias is *Katzman v. Rediron Fabrication*.[5] Here, the court found that a recurring trend in litigation was that treating physicians were providing care to plaintiffs referred to them by their counsel.[6] The treatment was provided under an agreement that the physician would defer collecting payment, through an LOP, until the conclusion of the plaintiff's case.[7] The court determined that the defense was entitled to explore the provider's financial bias and the provider's stake in the outcome when the provider elects to inject themselves into the litigation.[8] Simply put, the court is allowing the defendant to explore the financial relationship between the treating provider and the plaintiff's counsel based on the direct referral relationship that may exist. The court further mentions that LOPs serve as an assurance for the provider that he/she will be paid from the proceeds of the lawsuit.[9]

The existence of an LOP is an indicator that the treating physician may have financial motivation behind his/her testimony. When reviewing the treating provider's records, it is imperative to note when the LOP was requested and whom requested it. An argument that has been raised by the plaintiff's bar to support the use of LOPs is their necessity for some plaintiffs because without LOPs the plaintiff cannot afford the medical treatment he/she needs. A timeline is one way to combat this argument by illustrating for a jury when the accident happened, when the plaintiff first reached out to the treating provider, when the plaintiff first sought medical treatment, when the medical provider became aware of the plaintiff's lawsuit, when the LOP was requested, and when the plaintiff retained counsel. A timeline can help illustrate the financial motivation behind the provider's testimony. It can establish when the medical provider injected themselves into the litigation process. Moreover, the LOP is only one method of showing a referral relationship may exist between the treating provider and the plaintiff's counsel.

Landmark cases such *as Steinger, Iscoe & Greene, P.A. v. GEICO Gen. Ins. Co*.[10] and *Brown v. Mittelman*,[11] have expanded upon what information the defense is entitled to obtain regarding the relationship between the plaintiff's treating provider and the plaintiff's counsel. Both cases can be used together in order to illustrate that the treating provider has a financial incentive in the plaintiff's litigation.

Steinger directly disclaimed the alleged "hybrid witness" classification that had been argued for years by plaintiffs.[12] It also provides for the greatest scope of discovery that is allowed into a treating provider's finances by not limiting it to what typically would be allowed through expert discovery.[13] However, the defense must first establish either a direct or indirect referral relationship between counsel for the plaintiff and the treating provider before having greater latitude to explore their financial relationship.[14] Once the referral relationship is established, the defense is entitled to request documents directly from the treating provider regarding the extent of this relationship. This includes the amount of monies paid to the provider by the plaintiff's counsel and the number of LOPs issued to the provider by the plaintiff's counsel.[15] In the event that the provider does not maintain this information, *Steinger* allows the defense to obtain this information directly from the plaintiff's counsel.[16]

An obstacle many defense attorneys encountered after the *Steinger* decision was establishing the referral relationship.[17] The "how you were referred" requests started disappearing from treating providers' intake and initial paperwork. Plaintiffs' counsels objected to questions regarding how their clients found their provider. Typically, the providers either refused to respond or testified they could not remember. To combat this trend CSK attorneys began asking plaintiffs during their depositions whether they were referred to their treating provider through family, friends, coworkers, acquaintances, emergency room personnel, or the plaintiff's primary care physician. If a plaintiff answered "no" to the objected question "were you referred by your attorney," a motion to compel was

used to elicit a response. After eliminating the possible referral sources for the plaintiff, the argument was that the only person left to refer the plaintiff was his/her attorney.

The Fourth District Court of Appeal in *Brown v. Mittelman,* removed the requirement that the defense had to first establish a direct or indirect referral relationship before it could explore a provider's financial bias.[18] In *Brown*, the court clarified it never intended to limit the right of the defense to explore the potential financial bias a treating provider has by first requiring a referral relationship to be established.[19] *Brown* now allows the defense to obtain this information before establishing a referral relationship, provided its requests are geared towards uncovering an ongoing relationship between the treating provider and the plaintiff's counsel and are limited in terms of the timeframe.[20]

With the addition of the *Brown* decision, the defense can now illustrate to the jury the extent of the treating provider's financial bias and the motivation behind becoming an advocate for the plaintiff.[21] *Brown* allows the defense to explore whether a referral relationship exists between the treating provider and the plaintiff's counsel by determining whether an ongoing relationship is present. If established, the defense can then use the court's decision in *Steinger* to explore the extent of this relationship.[22]

This discovery is still relatively new and is being challenged by the plaintiffs' bar; however, once objections are fought through, what is left is a picture of the treating provider's vested interest in the outcome of not only the pending litigation, but in maintaining an ongoing source of income through the plaintiff's counsel. The plaintiffs' bar's argument that LOPs are needed in order to allow plaintiffs to obtain necessary treatment shows why treating providers are motivated to advocate for plaintiffs. Without a large award, the provider's chances of being paid are limited. Furthermore, by showing the jury that the treating provider's primary source of patients comes from plaintiff's lawyers, the defense can illustrate the provider's motivation to defend the inflated charges.

In the end, the defenses' goal at trial is to present the jury with an idea of what the reasonable value of the plaintiff's medical charges should be for the services provided. This can be done by contrasting what other medical providers, whose practices are not geared toward litigation, charge for similar services in the geographic area with the higher charges submitted by a provider whose primary clientele comes from litigation. Hopefully, by presenting and explaining to the jury what an LOP is, how it defers payment until the conclusion of trial, and the ongoing relationship the provider has with the plaintiffs' bar, the jury will see the treating provider's motivation as an advocate in the litigation. As a result, the question left with the jury is who has the motivation to bill an amount of reasonable value for the services provided, the provider whose reimbursement is contingent on obtaining a high award at trial or the provider who expects payment from a patient irrespective of litigation.

(Endnotes)

1 DAMAGES, JICIV FL-CLE 5-1

2 DAMAGES, JICIV FL-CLE 5-1

3 *Norman v. Farrow,* 880 So. 2d 557 (Fla. 2004).

4 *Goble v. Frohman*, 901 So. 2d 830 (Fla. 2005).

5 *Katzman v. Rediron Fabrication,* 76 So. 3d 1060 (Fla. 4th DCA 2011).

6 The situation presented in this case, which is recurring, involves a physician who treats a patient who was involved in an auto accident and referred by a lawyer. The physician enters into an LOP and agrees to collect payment from any recovery that is obtained in the law suit. In one respect, the physician is a "fact" witness, a treating physician. *Katzman v. Rediron Fabrication,* 76 So. 3d 1060, 1063 (Fla. 4th DCA 2011).

7 *Id.*

8 In another respect, the same physician often provides expert opinions at trial regarding the permanency of injuries, prognosis and the need for future treatment. The physician is not merely a witness retained to give an expert opinion about an issue at trial. Likewise this is not a typical treating physician that a patient independently sought out. A lawyer referred the patient to the physician in anticipation of litigation and therefore the physician has injected himself into the litigation. This witness potentially has a stake in the outcome of the litigation not because of the LOP—because of the referral by the lawyer. The LOP merely gives the doctor the assurance that his/her bill will be paid directly from the proceeds of any settlement or verdict. It is the direct referral by the lawyer to the doctor that creates a circumstance that would allow the defendant to explore possible bias on the part of the doctor. *Id.* At 1063-1064.

9 *Id*.

10 *Steinger, Iscoe & Greene, P.A. v. GEICO Gen. Ins. Co.,* 103 So. 3d 200 (Fla. 4th DCA 2012).

11 *Brown v. Mittelman,* 152 So. 3d 602 (Fla. 4th DCA 2014).

12 For purposes of uncovering bias, there is no meaningful distinction between a treating provider who is a witness and provides expert opinion (the so called "hybrid witness") and retained experts. *Id.*

13 We do not suggest that all financial discovery from a physician who also serves as an expert in litigation must always be strictly limited to those matters listed in Rule 1.280(b)(5)(A). We stress that the limitations on financial bias discovery from expert witnesses cannot be used as a shield to prevent discovery of relevant information from a material witness—such as a treating physician. The rule limits discovery of the general financial information of the witness where it is sought solely to establish bias. However, trial courts have discretion to order additional discovery where relevant to a discrete issue in a case. See *Rediron*, 76 So. 3d 1060, 1064-65 (Fla. 4th DCA 2011). In each case, the trial court must balance the need for the discovery against the burden placed upon the witness. *Id.*

14 There is a preliminary showing that the plaintiff was referred to the doctor by the lawyer (whether directly or through a third party) or vice versa, the defendant is entitled to discover information regarding the extent of the relationship between the law firm and the doctor. *Id.* at 205.

15 *Id*.

16 *Id.* at 206.

17 *Steinger, Iscoe & Greene, P.A. v. GEICO Gen. Ins.Co.,* 103 So. 3d 200 (Fla. 4th DCA 2012).

18 Whether the law firm directly referred the plaintiff to the treating physician does not determine whether discovery of the doctor/law firm relationship is allowed. *Brown,* 152 So. 3d 602, 604-5 (Fla. 4th DCA 2014).

19 In *Katzman v. Rediron Fabrication, Inc.*, 76 So.3d 1060, 1064 (Fla. 4th DCA 2011), we recognized a "direct referral by the lawyer to the doctor" as one circumstance that creates a potential for bias. However, contrary to Dr. Brown's assertion, we did not intend to limit discovery to that narrow situation. *Id.*

20 *Id*.

21 *Brown v. Mittelman,* 152 So. 3d 602 (Fla. 4th DCA 2014).

22 *Steinger, Iscoe & Greene, P.A. v. GEICO Gen. Ins. Co.,* 103 So. 3d 200 (Fla. 4th DCA 2012).

The Examination Under Oath Awakens

Stephen M. Rosansky, Esq.

A long time ago in what seems like a galaxy far, far away, a claimant's refusal to attend a properly and timely noticed Examination Under Oath ("EUO") meant that he or she had breached the terms and conditions of the insurance policy under which the claim was being made or, at the very least, had triggered the "no-action" clause thereof and was therefore forever precluded from making a successful claim against the insurer for personal injury protection (PIP) benefits.

In fact, before 2010, dismissal of claims under such circumstances was considered a *fait accompli* with both plaintiff and defendant mutually assured of the inevitable outcome of the litigation. This was, in part, because insurance policy provisions requiring an insured (omnibus insured) to submit to an EUO are quite common and have been recognized as valid and binding provisions for over a hundred years. *See Claflin v. Commonwealth Insurance Company*, 110 U.S. 81, 97, 3 Supreme Court 507 (1884)("by the insurance contract the companies were entitled to know from him all the circumstances of his purchase of the property insured . . . and false statements . . . under oath . . . [were] a breach of the conditions of the policy, and constitute the bar to the recovery of the insurance.")[1] This was so until the Florida Supreme Court's decision in *Custer v. United Automobile Insurance Company*, 62 So. 3d 1086 (Fla. 2010), which essentially eliminated the insurer's right to enforce such provisions.

Although EUOs were not directly at issue in *Custer,*[2] the Court, in *dicta*, stated that an EUO policy provision in the context of PIP is not a condition precedent to coverage or recovery of PIP benefits, as it conflicts with the Florida No-Fault law. *Custer Medical Center v. United Auto. Ins. Co.*, 62 So. 3d 1086 (Fla. 2011)[3] (wherein the Court stated that attendance at an examination under oath without counsel as a condition precedent to coverage is "contrary to the general principles of law concerning affirmative defenses and conditions precedent, as well as the principles underlying the PIP statute") *Custer*, 62 So.3d at 1089 n. 1 (footnote added); *accord* at 1095–96.

Three years later, the Florida Supreme Court in *Nunez v. Geico General Insurance Company*, 117 So. 3d 388 (Fla. 2013) sounded what many believed was the death knell of the EUO, holding (in reliance upon *Custer*) that under the PIP statute an insurer could not require the insured to attend an EUO as a condition precedent to recovery of PIP benefits, finding that although the PIP statute was silent as to EUOs, the statutory goal was to en-

sure swift and virtually automatic payment of benefits to insureds and enforcing EUO conditions clearly could and did cause delay and denial of benefits in contravention of the purpose of the PIP statute.[4]

"Without a doubt, the purpose of the no-fault statutory scheme is 'to provide swift and virtually automatic payment…" *Ivey v. Allstate Ins. Co.,* 774 So. 2d 679, 683–84 (Fla. 2000) (*quoting Gov't Employees Ins. Co. v. Gonzalez,* 512 So. 2d 269, 271 (Fla. 3d DCA 1987). Yet, while payment should be swift and virtually automatic, payment should not be without question and the legislative purpose must be tempered by the potential for abuse. Ever since the Second Interim 15th Statewide Grand Jury Report of 2000 was published, prompting the fraud legislation of 2001 and 2003, the Legislature has recognized the potential for abuse and the dangers of insurance fraud. Accordingly, the Legislature encouraged insurers to self-monitor the industry and protect their insureds against the unscrupulous. One such mechanism, historically relied upon by insurers, was the EUO, which permitted an insurer not only to verify the facts of the loss and injuries sustained and treatment allegedly rendered, but also to establish reasonable proof that it was not responsible for payment of bills submitted due to, amongst other things, fraud.

This is something that the Court in *Custer* and *Nunez* apparently failed to take into account.[5] The Legislature, however, saw fit to restore balance and expressly imbued to insurers the statutory right to conduct EUOs of an insured, including an omnibus insured, requiring compliance with the terms of the policy and the Statute as a condition precedent to receiving benefits. See Ch. 2012-197, §10, Laws of Fla. (amending/creating §627.736(6)(g), Fla. Stat., effective 1/1/13). The Examination Under Oath Awakens…

Many insurers survived the three year absence of the EUO by requesting recorded statements. EUOs and recorded statements are not the same thing. *Goldman v. State Farm Fire Gen. Ins. Co.*, 660 So. 2d 300 (Fla. 4th DCA 1995). A recorded statement is typically an informal proceeding taking place only a short time after the loss is reported. The questions asked are usually standard in nature and often asked verbatim from a written form. The statements are sometimes audio-recorded by the adjuster, but sometimes there is no record of the statement other than the notes of the person conducting it. EUOs, on the other hand, are more formal and detailed in nature and are almost always taken by an attorney engaged by the insurance company. The questions and answers are transcribed by a court reporter and the insured is typically required to sign the transcript. Another distinction is an EUO is literally "under oath," meaning that the insured legally swears or affirms that his or her answers are truthful. Note, however, this article is not intended to dissuade you from taking recorded statements because one is not a substitute for the other and each may be used to complement the other. Likewise, EUOs and depositions are not the same.

When *Custer* was applicable, some insurers resolved themselves to obtaining information by and through depositions once suit was filed. 62 So. 3d at 1086. While a deposition, like an EUO is taken by an attorney and is taken under oath, a deposition often occurs many years after the subject loss, when memories have faded and evidence has otherwise been degraded or lost. Moreover, unlike EUOs, depositions are taken in the presence of opposing counsel, who has a right to cross-examine the witness and in many instances (given their common interest in getting the bills paid) prepare the witness to provide favorable testimony. EUOs, conversely, are typically taken much closer in time to the loss and may be taken outside the presence of counsel for the provider, making it a far more useful investigative tool. The EUO is an investigative tool that can and should be used, when appropriate, to assess the veracity of the claim and make an appropriate claim decision, perhaps avoiding unnecessary litigation.

(Endnotes)

1 See *Pervis v. State Farm Fire & Casualty,* 901 F. 2d 944 (11th Circuit 1990); *Southern Home Insurance Company v. Putnal*, 49 So. 922 (Fla. 1909); *Diaz v. Bankers*, 702 So. 2d 1324 (Fla. 3d DCA 1997); *American Reliance Insurance Company v. Riggins*, 604 So. 2d 535 (Fla. 3d DCA 1992). *See also Marlin Diagnostics (a/a/o Fidencia Correa) v. State Farm Mut. Auto. Ins. Co*., Case No. 02-25036 CA 30 (11th Judicial Circuit in and for Miami-Dade County, J. Levinson)(for the proposition that the courts have consistently upheld insurance contracts containing provisions which require the insured to submit to Examinations Under Oath.) *See also Stringer v. Fireman's Fund Insurance Company*, 622 So. 2d 145 (Fla. 3d DCA 1993); *Fassi v. American Fire and Casualty Company*, 700 So. 2d 51, 52-53 (Fla. 5th DCA 1997); G*oldman v. State Farm Fire General Insurance Company,* 660 So. 2d 300, 303-304 (Fla. 4th DCA 1995) ("We conclude that the policy provisions requiring appellants to submit to examinations under oath are conditions precedent to suit rather than cooperation clauses.")

2 In which this Court's primary holding was that the underlying district court of appeal had misapplied the standard of review on second-tier certiorari review of a case involving an insurance company's denial of PIP benefits based on the insured's failure to appear for a medical examination. 62 So.3d at 1088–89.

3 *United Auto. Ins. Co. v. Diaz*, 18 Fla. L. Weekly Supp. 348a (11th Cir. Ct. (Appellate) Feb. 3, 2011). "[T]he PIP statute does not impose an EUO condition upon the insured." *United v. Diaz*. While an insurer may seek to require an EUO through its policy where a PIP claim is presented, the Court finds that failure for the insured to attend an EUO does not serve as a bar to payment of PIP benefits. *See Mejias Medical Center a/a/o Yordanka Bulit v. Esurance*, 18 Fla. L. Weekly Supp. 693d (11th Cir. Ct. (Appellate) Feb. 3, 2011). In reaching this conclusion, the Court has considered *Mercury Insurance Company v. Dr. Garrido a/a/o Erix Dolz*, 18 Fla. L. Weekly Supp. 575a (11th Cir. Ct. (Appellate) Apr. 7, 2011) (finding that an EUO provision is not a condition precedent to recovery of benefits and calling into question the validity of such provisions) and *State Farm Fire & Casualty Company v. Suncare Physical Therapy*, 18 Fla. L. Weekly Supp. 776a (11th Cir. Ct. (Appellate) July 13, 2011) (finding an EUO provision is a valid condition precedent to suit).

4 Disapproving *Shaw v. State Farm Fire and Cas. Co.*, 37 So. 3d 329 (Fla. 5th DCA 2010).

5 *Custer and Nunez* would be superseded by Statute in 2013. *See Lewis v. Liberty Mutual Insurance Company,* 121 So. 3d 1136 (Fla. 4th DCA 2013).

SUCCESS -Stories-

Michelle Bartels of CSK's Tampa office obtained a Summary Judgment in Hillsborough County. The plaintiff claimed he was injured following a slip and fall on water in the men's restroom of a restaurant. At the time of the accident, the plaintiff suffered from Parkinson's, Alzheimer's, and Dementia and was not able to testify as to the cause of his fall. Ms. Bartels relied upon Florida Statute §768.0755 and successfully argued that the plaintiff failed to prove that the restaurant had actual or constructive notice of the water, as there was no testimony or evidence in the record to support the plaintiff's allegations.

Steven P. Befera and **Dana Chaaban** of CSK's Miami office obtained a Final Summary Judgment in favor of our client's business tenant. This case arose from a criminal battery where the plaintiff alleged he was shot in a night club. As a result of the shooting, the plaintiff was rendered paraplegic. The plaintiff and his son brought a lawsuit claiming negligence by the defendant in failing to provide adequate security to the premises. Steven and Dana filed a Motion for Final Summary Judgment in response to the Complaint pursuant to Fla. R. Civ. P. 1.510 (b) successfully arguing that under the lease, the defendant had no control over the management of the business being conducted by the lessee, including its security, and that since the shooting took place inside the demised premises (and therefore outside the lessors' control) the lessors could not be liable as a matter of law.

Anika Campbell and **Kate Woods** of CSK's West Palm Beach office obtained a Final Summary Judgment based upon the expiration of a statute of limitations for declaratory relief. The plaintiff, a unit owner in a multi-condominium, brought an action for declaratory relief as to whether the insured association was responsible for the expenses of certain recreational areas within the community. The plaintiff wanted the association to pay for extensive repairs and maintenance to the condo recreational areas, including the parking garages, tennis court and pool.

The court granted Summary Judgment for the association in line with the recent Fourth District Court of Appeal case, *Harris v. Aberdeen*, 135 So. 3d 365, which held a cause of action for declaratory relief based upon an association's declaration accrues on the date the owner takes title to his or her property. The plaintiff took title to the condo within the insured association in 1991, and, thus the five year limitation for legal or equitable actions based upon a written instrument had expired.

Lee Cohen and **Stephen Harber** of CSK's West Palm Beach office obtained a very favorable trial result/ settlement. The plaintiff, a 64 year old horseback rider, took additional riding lessons with our client. During a lesson, the horse unexpectedly threw the plaintiff into a fence, causing her to sustain multiple fractured ribs, a punctured lung, and a fractured shoulder. The plaintiff incurred nearly $300,000.00 in medical bills and filed suit against our client. The plaintiff filed Proposals for Settlement for $600,000.00 & $400,000.00. Our client made a $100,000.00 offer through a Proposal for Settlement prior to trial. After two full days of trial the plaintiff sought to settle the case globally for $50,000.00.

Lee Cohen and **Jim Sparkman** of CSK's West Palm Beach office obtained a complete defense verdict in a week and half long jury trial. The plaintiff claimed she tripped and fell in the entranceway of an office building due to the negligent placement of a planter. The plaintiff underwent 3 low back surgeries, ultimately fusing four levels of her lumbar spine. The past medical bills presented at trial totaled $1,016,000.00. The plaintiff asked for either $175,000.00 or $554,000.00 in additional future medical care and $117,000.00 for consortium damages. To establish the defendant's negligence the plaintiff relied upon her and her friend's testimony, an engineering expert, and a visual perception expert. After the plaintiff rested, Mr. Cohen and Mr. Sparkman strategically decided not to present their case, as they knew the plaintiff failed to prove her case. During closing arguments, the plaintiff asked the jury to double the non-economic damages for pain and suffering and suggested she was 10% at fault for her injuries. The jury deliberated for an hour before returning a verdict in favor of our client.

Blake S. Sando and **Kelly G. Dunberg** of CSK's Miami office obtained Final Summary Judgment in favor of an insurance agent in a negligent procurement lawsuit in Broward County. Relying on *Tiara Condo. Ass'n, Inc. v. Marsh, USA, Inc.*, 991 F. Supp. 2d 1271 (S.D. Fla. Jan. 13, 2014), the defendant argued that it did not owe any duty to advise the plaintiffs of their coverage needs because there were no facts evidencing a "special relationship" giving rise to such a duty. The court agreed with the Defendant's argument and granted final summary judgment in favor of the Defendant.

Jami Gursky of CSK's Fort Lauderdale office obtained a finding of no probable cause in an administrative action initiated by the Department of Health ("DOH"). In this particular case, the DOH investigated whether a physician negligently administered an intraocular injection, causing blindness. Mrs. Gursky has prevailed on 10 of 11 administrative actions; the sole probable cause finding was issued on a wrong sided surgical case where liability was admitted. Other success stories involve surgical perforations, wrong-sided surgical sites, failed root canals, failure to monitor during outpatient detox procedures causing death, failure to diagnose and treat, negligent post-surgical handling, and more.

Edward S. Polk of CSK's Miami office obtained a dismissal of a plaintiff's claim and final judgment for the defendant in a personal injury claim, based on the plaintiff's fraud on the court. The plaintiff claimed while sitting on a bench at a home improvement store a fire extinguisher fell off the wall and struck her in the neck causing serious injury requiring surgical intervention. The theory against our client the fire extinguisher was improperly remounted. With medical bills in excess of $100,000.00 the plaintiff assigned a very high value to her case.

Aggressive discovery and investigation into the plaintiff's background revealed several prior and subsequent incidents in which the plaintiff had re- ported to medical providers with com- plaints of neck pain. After an evidentiary hearing in which the plaintiff was examined as to each of these episodes and attempted to explain her false answers, the court entered a detailed 17 page order enumerating the falsehoods proven by the testimony and evidence, and entered final judgment for the defendant on the basis of fraud on the court. Our client now has the opportunity to seek a judgment for attorney fees and costs on the basis of a Proposal for Settlement that the plaintiff refused to accept.

Thomas E. N. Shea of CSK's Bonita Springs office obtained a Final Summary Judgment in a negligence case involving a landscaping employee that sued our insured, a homeowner, after he sustained injuries while performing lawn care and landscaping services at the insured's property.

When one of the plaintiff's coworkers drove over or near a rut in the yard, an object was projected from the lawnmower which struck the plaintiff and severed his Achilles tendon. Mr. Shea filed a motion for Final Summary Judgment and argued that Florida law does not impose a duty upon landowners to provide safe working environment for employees of independent contractors, the plaintiff's knowledge of any dangerous condition was equal or superior to the insured's knowledge, and a rock or shell in a yard is simply not a dangerous condition that imposes a duty to warn in this context. The court agreeing entered Final Summary Judgment.

Steven P. Befera and **Brittany Borck** of CSK's Miami office received a favorable verdict in a jury trial. The plaintiff, a 75 year old female, sustained serious injuries while walking on a wood dock owned by a condominium association, our client, which was under repair. The plaintiff alleged that our client and the general contractor it hired created a dangerous condition and were negligent in failing to provide adequate warnings and safeguards against the dangerous condition (an opening in the dock left unsecured through which she fell). Our client served a Proposal for Settlement in the amount of $35,000.00. The plaintiff's pre-trial demand was $250,000.00. After a five day trial, the jury awarded the plaintiff $38,157.00, and found our client to only be 15% at fault, the general contractor to be 25% at fault, the plaintiff 10% at fault, and the *Fabre* defendants (the condo unit owners she was visiting at the time) 50% at fault. As a result of the verdict/expected judgment being less than 25% of the Proposal for Settlement, our client should be entitled to fees and costs exceeding the judgment.

Scott Welner and **Randy Rogers** from CSK's Pensacola office obtained a Final Summary Judgment in two wrongful death and three serious injury consolidated cases. These matters involved a brutal attack by a resident of a townhome community in Destin, Florida. A shotgun was fired several times into the downstairs window of a townhome filled with foreign exchange students - two students died and three others were seriously wounded. For four years, CSK defended the homeowners association and a community association management company against wrongful death and premises liability claims brought by the estates of the deceased and the three survivors.

The day before the first hearing on the Summary Judgment motion, plaintiffs' counsel filed an affidavit from an investigator aimed solely at defeating Summary Judgment. After emergency motions and an initial denial of the motion for Summary Judgment, Mr. Welner filed a Motion to Strike the Affidavit and argued the affidavit contained hearsay and other improper evidence. The judge eventually struck the affidavit and granted a renewed motion for Final Summary Judgment finding that the shooting was unforeseeable and the clients did not breach any duty owed to the students

Scott Cole and **Brian Dominguez** of CSK's Miami Office obtained an affirmance in the Second District Court of Appeal of an order granting Final Summary Judgment in a premises liability action. CSK successfully argued that the daughter, who was also listed on the title for the property, could not maintain a cause of action against her mother as a result of her injury on the property. Following oral argument, the Second District Court of Appeal affirmed.

Katie Smith of CSK's Miami Office obtained an order granting a Petition for Writ of Certiorari and quashing a trial court's order permitting discovery in a legal malpractice claim while the underlying foreclosure litigation was still pending. Despite the fact that the underlying foreclosure litigation was still pending, the Plaintiff filed a lawsuit for legal malpractice against the defendants. The defendants moved to stay or abate the malpractice action pending the foreclosure litigation. The trial court granted the motion, in part, as it related to any trial of the malpractice action; however, the trial court permitted discovery to move forward on the issue of liability. The defendant filed a Petition for Writ of Certiorari and the Fourth District quashed the trial court's order. In its opinion, the Fourth District held that the malpractice action must be stayed or abated until there is a judgment against the plaintiffs in the underlying action. The court also held that no exception is warranted for damages already incurred by the plaintiff.

Katie Smith of CSK's Miami Office obtained a written opinion in the Eleventh Circuit Court of Appeals affirming the district court's order granting two defendants' motions to dismiss in a securities class action lawsuit. The lawsuit claimed that several defendants fraudulently induced the plaintiffs to invest in a Chinese pharmaceutical company by misrepresenting the company's financial condition and failing to disclose information relevant to the company's actual financial condition. As a result, the plaintiff's alleged that they suffered substantial losses on their investments. In their motions to dismiss, the defendants argued that there were no allegations of scienter sufficient to support a cause of action against them for securities fraud. The Eleventh Circuit agreed with the district court and held that the plaintiffs failed to adequately plead any theory of fraud that is specific enough in scope to support a strong inference of scienter, affirming dismissal as to these two defendants.

Daniel Schwarz of CSK's Fort Lauderdale East Office obtained a written affirmance from the Fourth District Court of Appeal following a defense verdict in a negligent security action. The plaintiff was shot in the leg during an altercation at a party in the common area of CSK's client, a government-subsidized housing development. The plaintiff had previously resided at the complex but had been evicted years earlier. At trial, CSK presented evidence from the defendant's property manager and a police officer that the plaintiff had previously been warned to leave, and therefore was a trespasser at the time of the incident. Both at trial and on appeal, the plaintiff argued that her status with respect to the defendant's property was irrelevant, because her cause of action was grounded in ordinary negligence, not premises liability. The Fourth District Court of Appeal, in a written opinion, rejected the plaintiff's argument, agreed with CSK, and clarified that Florida law indicates that a plaintiff's relationship to the land is relevant in an action for negligent security.

Scott Cole, Daniel Schwarz, and **Benjamin Esco** obtained a *per curiam* affirmance of a Final Judgment entered on a jury verdict in the Third District Court of Appeal in a case regarding the authority of a condominium's board of directors to make alterations to association property. The defendant condominium association made several million dollars' worth of repairs and improvements to its boat basin and marina, without ordering a vote of the unit owners, and imposed a special assessment. The forty-year-old boat basin was substantially dilapidated, and the board's changes encompassed repairs and upgrades to the basin's docks, cleats, pilings, piers, electricity, and supply lines. The plaintiffs, five unit owners, filed suit alleging that the board acted contrary to its condominium documents by making alterations and improvements without obtaining prior written approval of 75% of the unit owners. After a seven-day trial, CSK obtained a jury verdict finding that while the board's repairs constituted alterations, the changes were reasonably necessary to repair, maintain, or preserve association property, and thus fell within an exception to the unit owner vote requirement. On appeal, the plaintiffs argued error in the jury instructions and verdict form, in that the legal standard was whether the alterations were simply "necessary," not "reasonably necessary." The Third District Court of Appeal disagreed, affirmed the final judgment entered on the jury's verdict, and denied the plaintiffs' motion for a written opinion.

Denise Murray of CSK's Tampa office secured a complete defense verdict in a potential large loss workers' compensation case. The claimant was a 51-year-old painter who fell 20 feet from a ladder and suffered significant injuries, including bilateral upper extremity fractures, left hip and leg fractures, loss of vision in his right eye and loss of hearing in both ears. His medical bills exceeded $300,000.00. He was permanently and totally disabled.

The claimant alleged that our client was his statutory employer because our client was involved in the selection of the general contractor for the project, drafted the documents between the owner and general contractor, had an office located on the job site and oversaw the construction of the project. The employer/carrier denied coverage for the claim on the basis that there was no employer/employee relationship and our client was not his statutory employer. The judge agreed and denied all benefits.

TRIVIA

OFFICIAL RULES

NO PURCHASE NECESSARY. PURCHASE WILL NOT INCREASE YOUR CHANCES OF WINNING. Void where prohibited. This contest is sponsored by Cole, Scott, & Kissane P.A. A total of 10 prizes available to be awarded. No cash prizes. Each prize is valued at $10.00. Odds of winning will depend upon the number of eligible entries received (estimated odds based upon the number of Quarterly readers: 1 in 1000). Contest is open to anyone in the United States who is 18 years of age or older. Employees of Cole, Scott, & Kissane P.A. are not eligible to participate. Contest begins at 12:01 a.m. (EST) on **May 1, 2015.** Entries must be received by 12:00 p.m. (EST) on **June 15, 2015.** Entries must also include contestant's name and mailing address. Winners will be chosen according to the first 10 eligible responses received that correctly answer the Trivia Question. If less than 10 correct entries are received, remaining prizes will be awarded at random to other participants.

Entries must be e-mailed to Quarterly.Trivia@csklegal.com. Limit of one entry per household. Winners will be selected on **June 17, 2015** and notified via e-mail by **June 18, 2015.** If you do not wish to receive or if you would like to be removed from subsequent mailings, please call, toll free, at 1-888-831-3732. A list of winners can be obtained after **June 22, 2015** via e-mail to: eric.rieger@csklegal.com. Cole, Scott, & Kissane P.A. is not responsible for any lost e-mail or technical problems encountered by contestants in connection with this contest.

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