STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS
OFFICE OF THE JUDGES OF COMPENSATION CLAIMS
FT. LAUDERDALE DISTRICT OFFICE

Robert McNiven,
Employee/Claimant,

vs.

YRC/Gallagher Bassett Services, Inc.,
Employer/Carrier/Servicing Agent.

OJCC Case No. 13-013876GBH

Accident date: 10/25/2007

Judge: Geraldine B. Hogan

FINAL COMPENSATION ORDER

After due and proper notice to the parties, the above entitled cause came before the undersigned Judge of Compensation Claims on February 19, 2014. This order resolves the petition for benefits filed on June 18, 2013. For reasons set forth below I find that the petition is barred by the statute of limitations.

A. Stipulations:

The parties stipulated to the following:

1. The undersigned has jurisdiction over the parties and subject matter.
2. That venue of the claim is in Broward County.
3. There was an employer/employee relationship on the date of accident.
4. Workers' compensation insurance coverage was in effect on the date of accident.
5. The average weekly wage (AWW) is $823.85 and the corresponding compensation rate (CR) is $549.26.

B. Claims and Defenses:

1. Claims were made for the following benefits:
   a. TTD/TPD from date of accident to present and continuing at correct compensation rate.

b. Correct determination of AWW to include $22.50 per hour for 40 hours per week plus overtime and fringe benefits[1].

c. Continued treatment with orthopedic or PCP for the right and left elbows. At final hearing Claimant specifically named Dr. Hersch as the requested provider.

d. Penalties, interest, attorney's fees and costs.

2. The Employer/Carrier asserted the following defenses:
   a. Statute of Limitations ran on this claim; no further entitlement to benefits under workers' comp.

   b. All indemnity due or owed was paid timely.

   c. No TTD or TPD due or owed.

   d. Overpayment of past temporary benefits still owed to E/C.

   e. No objective medical evidence to support entitlement to TTD or TPD.

   f. Claimant is at MMI.

   g. No correction of AWW/CR due or owed; AWW/CR was correctly calculated.

   h. No objective medical evidence to support medical necessity or major contributing cause of any need for treatment with PCP for right and left elbows.

   i. No PICA due or owed.

3. Claimant's Objections/Responses to Affirmative Defenses: E/C is estopped from claiming a SOL defense based on omission or inaction by the E/C.

C. Documentary Evidence:

Judges Exhibits

1. Pretrial Stipulation
2. Petition for Benefits and Response to Petition for Benefits (composite)

[1] At the initiation of the final hearing the parties stipulated to the AWW/CR. Claimant, through counsel, advised that this was no longer an issue.

Joint Exhibits

1. Deposition Transcript of Susan Huffine-Athanasopoulos with exhibits

Claimant's Exhibits

1. Deposition Transcript of Jonathan Hersch, M.D. with exhibits
2. Claimant's Trial Outline (Identification)
3. Amendment to Pretrial Stipulation
4. Notice of Filing dated 02/16/ 2014 with compensation orders (Identification)

Employer/Carrier's Exhibits

1. 06/18/2013 – Deposition Transcript of Robert McNiven
2. 01/21/2014 - Deposition Transcript of Robert McNiven with exhibit
3. Employer/Carrier's Trial Summary and Memorandum of Law (Identification)

D. Live Testimony: None

E. Findings of Fact and Conclusions of Law: Upon consideration of the evidence presented, the argument of counsel and the stipulations of the parties, I find as follows:

1. The Claimant worked for the employer as a driver and dock worker. On October 25, 2007 he slipped and fell at work injuring both elbows. E/C accepted the accident as compensable. The carrier provided authorized medical care with Concentra in Miami, Westside Regional Hospital and orthopedic surgeon, Jonathan Hersch, M.D. The carrier also provided attendant care, pursuant to the recommendation of Dr. Hersch. Additionally, the carrier paid TTD and TPD benefits.

2. According to the Claimant's testimony he has not seen a doctor for the injuries to his elbows since Dr. Hersch placed him at MMI on June 10, 2008. Claimant testified that Dr. Hersch informed him that he could have issues with arthritis and clicking or cracking in his elbows at some point and that arthroscopic surgery could be a possibility in the future.

3. Claimant recalled receiving a letter dated July 23, 2008, which he identified during his January 21, 2014 deposition. The letter advised him that he was placed at MMI, that he had to pay a $10.00 copayment at the time of each doctor's visit and 1 year from the date of last treatment, the Statute of Limitations will run on his claim.

4. During his January 21, 2014 deposition Claimant was asked, "...So is it fair to say, then, you had a general understanding that under Workers' Compensation, you have an obligation to go back to the doctor once a year in order to keep your case open, on into the future?" Claimant answered, "Yes, sir. I understand that." (E/C Exhibit #2 pg. 22:19)

5. Claimant had a subsequent accident while working for the same employer on November 16, 2009. He injured his low back trying to maneuver a pallet jack. He recalled receiving similar correspondences regarding MMI, copayments and the Statute of Limitations following the 2009 accident.

6. Letters dated July 23, 2008 and October 5, 2010 advised the Claimant that, "... the Statute of Limitations will run 1 year from the last date of medical treatment." Additionally, both letters advised the Claimant to call the claims representative, Susan Huffine-Athanasopoulos, if he had any questions regarding the benefits discussed in the correspondences.

7. Susan Huffine-Athanasopoulos, the claims adjuster, began handling the October 25, 2007 accident in 2008. There were other adjusters previously assigned to handle the claim. The accident was reported the same day it occurred and the carrier accepted the accident and bilateral elbow injuries as compensable.

8. The adjuster testified that once a claim is reported a computer generated acknowledgment letter is sent to the claimant. The adjuster then sends out the Florida brochure, the Florida insurance letter and a contact letter. From reviewing the file, the adjuster determined that the acknowledgment letter was sent to the Claimant. She could not determine whether or not the brochure went out [in 2007].

9. The adjuster testified that the Claimant had a subsequent accident with the same employer on November 16, 2009. The accident was reported the following day. The carrier accepted the accident and low back injury as compensable. The adjuster sent an acknowledgement letter to the Claimant on November 19, 2009. The adjuster sent out the informational brochure and the department of insurance letter to the Claimant on November 20, 2009 along with a cover letter, which mentioned the statute of limitations.

10. According to the adjuster's testimony the carrier paid TTD benefits from October 26, 2007 through November 24, 2007 and TPD benefits from November 25, 2007 through January 26, 2008. The Claimant returned to work with the employer full duty on January 27 [2008].

11. The adjuster testified that after the Claimant returned to work on November 25, 2007 he received 85 percent of his contractual hourly rate. The carrier paid a portion and the employer paid a portion.

12. According to her testimony the amount of pay injured workers received from the carrier and the employer when on light duty status is greater than the TPD benefits that would be paid pursuant to the statute[2]. The adjuster testified that she had Claimant's actual earnings for the period in which TPD benefits were paid.

13. The adjuster testified that the prior adjuster used an average weekly wage of $888.40 with a compensation rate of $592.29, which resulted in an overpayment of TTD and TPD benefits. She further stated that the correct average week wage was $823.85 and the compensation rate was $549.26. When Claimant was placed at MMI the carrier did not pay impairment income benefits (IIBs) because of the overpayment of temporary indemnity benefits. The adjuster testified that she prepared a DWC-4 explaining that the carrier was taking an offset based on the overpayment of TTD and TPD benefits.

14. A Notice of Action Change (DWC-4) dated July 23, 2008 explained that the Claimant was placed at MMI on 6/10/2008 with a 1% permanent impairment rating. This document also noted that an AWW of $888.40 and a corresponding compensation rate of $592.29 were changed retroactive to the date of accident. The amended AWW was $823.85 and the amended compensation rate was $549.26. This document indicated that the Claimant was overpaid $1,549.79. A payment of $411.96 was due for impairment income benefits, which reduced the overpayment from $1,549.79 to $1,137.83. The adjuster noted that the remaining overpayment would be deducted from any future payments.

15. The adjuster testified that she thought it would be okay not to pay IIBs because the amount due in IIBs was so minimal and the overpayment was so large. She testified that the MMI letter and the DWC-4, explaining why IIBs were not paid, were both sent to the Claimant on July 23, 2008.

16. The adjuster testified that, according to the payout ledger, the carrier authorized and paid for attendant care regarding the October 25, 2007 accident from October 29,

[2] At final hearing Claimant's counsel asserted that Claimant did not receive any TPD benefits from 12/09/2007 to 12/15/2007 and from 12/30/2007 to 1/05/2008. Claimant's counsel further asserted that there was an underpayment of TPD benefits from 12/23/2007 to 12/29/2007 and 01/20/2008 to 01/26/2008. However, the adjuster was not asked about the alleged missing payments and underpayments during her deposition testimony.

2007 through November 2, 2007 pursuant to a prescription provided by Dr. Hersch. The carrier received notice of the attendant care prescription on October 26, 2007. The prescription was for four to six hours a day Monday through Friday until further notice.

17. A DWC-25 dated 10/30/07 noted that attendant care was recommended. The next DWC-25 included with Claimant's Exhibit #1 is dated November 6, 2007. It did not include an Attendant Care recommendation.

18. Pursuant to a claim note dated November 5, [2007] the case manager spoke with the Claimant and the Claimant advised that he did not want continued home health care because his father-in-law was coming to assist him. The attendant care provider was advised to discontinue services. Ms. Athanasopoulos did not know whether or not the Claimant was advised that his family member could receive payment for providing attendant care.

19. Jonathan Hersch, M.D., an orthopedic surgeon, first evaluated the Claimant on October 26, 2007. According to his testimony the Claimant sustained a radial head fracture to his right elbow and a radial neck fracture to his left elbow. Treatment included temporary splints and physical therapy. Dr. Hersch last saw the Claimant on June 10, 2008.

20. Dr. Hersch stated that on June 10th Claimant did not have any complaints of pain in either elbow and the fractures were healed. He testified that the Claimant complained of clicking in the right elbow. He indicated that this condition could have been caused by a little scar formation. As he recalled, the clicking in Claimant's elbow mostly dissipated. Dr. Hersch testified that occasionally, if the clicking bothers a patient he could undergo arthroscopic surgery. He indicated that if the Claimant had complaints of popping, it would only be appropriate to undergo surgery if the symptoms were really bothersome to him. When asked if it would be appropriate for the Claimant to undergo surgery if he continues to have the clicking and popping sound in his elbow, Dr. Hersch stated that, "It's reasonable to discuss it".

21. Dr. Hersch testified that he never formally communicated the possibility of surgery to the carrier. Information regarding possible surgery would have been included in the notes. He stated that he was sure that he told the Claimant to come back if this bothered him.

22. Dr. Hersch placed the Claimant at MMI on June 10, 2008 and assigned a 1% permanent impairment rating. He stated that as of that date, there was likely no future treatment recommended. According to his testimony he neither recommended, nor was he aware of the Claimant using any type of orthopedic devices, braces, splints, bandages or anything of that nature, when he last saw him.

23. According to the adjuster's testimony the carrier did not pay any indemnity benefits, provide medical treatment, durable medical equipment, or prescription medications after July 10, 2008. There was no activity on the file subsequent to July 10, 2008 until Claimant filed a petition for benefits. The adjuster did not have the exact date the carrier received the petition, but stated that the file was reopened on July 29, 2013. According to Judge's Exhibit #1 the petition for benefits was filed on June 18, 2013.

Statute of Limitations

24. A claimant is barred from filing a petition for benefits unless the claim is filed during the longer of the following two periods of time: (1) within two years from the date of the injury; or (2) within one year from the payment of indemnity benefits or the furnishing of remedial treatment, care or attendance pursuant to either a notice of injury or a petition for benefits. Claims Management, Inc. and Wal-Mart Store # 1960, Tampa v. George Philip, 746 So. 2d 1180, 1182 (Fla. 1st DCA 1999).

25. It was undisputed that Claimant filed the petition more than two years after the date of accident and more than one year after the last provision of benefits. Additionally, E/C's assertion that the SOL defense was raised in the first responsive pleading was not contested.

26. After the E/C raises a statute of limitations defense, the claimant must prove that the E/C should be estopped from raising the defense. The burden of proof on the claimant is a preponderance of the evidence, unless the E/C has complied with sections 440.185[3]and 440.055[4], in which case the claimant has a higher burden of

[3] Sec. 440.185(4) Fla. Stat. (2007) provides, in part, that, "Within 3 days after the employer or the employee informs the carrier of an injury the carrier shall mail to the injured worker an informational brochure approved by the department which sets forth in clear and understandable language an explanation of the rights, benefits, procedures for obtaining benefits and assistance, criminal penalties, and obligations of injured workers and their employers under the Florida Workers' Compensation Law…."

[4] Sec. 440.055 Fla. Stat. (2007) provides that an employer who employs fewer than four employees, who is permitted by law to elect not to secure payment

proof- clear and convincing evidence. Crutcher v. School Board of Broward County and Gallagher Bassett Services, Inc., 834 So. 2d 228, 230 (Fla. 1st DCA 2002)

27. E/C asserted that, pursuant to Crutcher, even if they do not establish that they met the requirements of 440.185 Fla. Stat. Claimant still has to prove estoppel by a preponderance of the evidence.

28. Claimant cited, among other cases, Robinson v. St. Johns School District 973 so. 2d 598 (Fla. 1st DCA 2008) for the proposition that misrepresentation of information provided by the E/C tolled the statute of limitations.

29. In Robinson the E/C initially accepted compensability of a claim, but later denied the claim on the grounds that the disability was not a result of the job-related injury, but instead related to a pre-existing condition. The E/C reported to the Claimant and the Division a permanent injury rating of zero percent. Three weeks later E/C received information from the Claimant's doctor indicating that the Claimant reached maximum medical improvement and had a 10% impairment rating. The E/C never advised the Claimant of the 10% rating. When claimant learned of the 10% impairment rating and filed a petition requesting permanent total disability benefits, the JCC held that the claim was barred by the statute of limitations.

30. In reversing the decision of the JCC the First District held that E/C were estopped from relying on the statute of limitations defense because the Claimant showed by clear and convincing evidence that E/C misrepresented a material fact, Claimant relied on the misrepresentation, and as a result, Claimant changed position to her detriment. Id. at 599.

31. The court found that the E/C notified the claimant of the doctor's zero percent permanent impairment rating but failed to correct or change the rating to ten percent after receiving that information. The court also found that the claimant relied on the misrepresentation because, as workers' compensation is an employer-administered system, the claimant had no reason to suspect the doctor's rating was other than zero percent. The court also determined that the claimant chose not to file a PFB in light of her belief that no portion of her disability was attributable to the workplace injury. The court found that the claimant's change of position was to her detriment

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of compensation under this chapter, and who elects not to do so shall post clear written notice in a conspicuous location at each worksite directed to all employees and other persons performing services at the worksite of their lack of entitlement to benefits under this chapter.

because the ten percent permanent impairment rating suggested that she had a viable entitlement to benefits. Id. at 600.

32. The facts before me are distinguishable from Robinson. After the Claimant reached MMI from the 10/27/07 accident the adjuster sent the Claimant a letter advising him of his obligation to pay a $10 co-payment for continued medical treatment and that 1 year from the date of last treatment, the statute of limitations would run on his claim. The letter also advised the claimant to contact the adjuster if he had any questions regarding the benefits discussed in the letter. Moreover, following the 11/16/09 accident, the adjuster sent Claimant the informational brochure.

33. Under Florida law, if the employer breaches its duty to inform the employee of his rights, the running of the statute of limitations will be tolled until such time that the employee obtains actual knowledge from any source that he may be entitled to compensation benefits. Southern Bell v. MacDonald, 671 So. 2d 207, 210 (Fla. 1st DCA 1996). In the case at bar, even though E/C failed to send the informational brochure pursuant to sec. 440.185(4) following the 2007 accident, the evidence supports a finding that the adjuster sent the informational brochure in November of 2009. The two year limitations period would have expired in November of 2011, prior to the filing of the petition in June of 2013.

34. Claimant also asserted that E/C is estopped from relying on the statute of limitations defense as a result of its continued inactions and failure to fulfill its continued obligation of placing the needed benefits in the hands of the injured worker when they knew or should have known such benefits were due. To support this assertion Claimant cited Sistrunk v. City of Dunedin, 513 So. 2d 200 (Fla. 1st DCA 1988) and Gauthier v. Florida International University, 38 So. 3d 221 (Fla. 1st DCA 2010).

35. In Sistrunk the First District held that the deputy commissioner erred in finding that the claimant was entitled to retroactive attendant care services five hours a day from the date of the filing of the claim. The unrefuted testimony of claimant's wife and medical providers supported a finding that the Claimants' wife should be compensated for no less than eight hours per day of attendant care services. The court held that sec. 440.13(2)(b) Fla. Stat. requires the employer to provide nursing care benefits, even though not requested, if the nature of the injury requires such benefits. The claimant was released from the hospital in a full body cast and the court held that the E/C could not in good faith assert that it was unaware of the Claimant's need for attendant care in the face of the self-executing nature of the Workers' Compensation law. Sistrunk v. City of Dunedin, 513 So. 2d at 202.

36. In the case at bar, Claimant asserted that he was entitled to attendant care up through November 20, 2007 per Dr. Hersch. The evidence does not support a finding that Dr. Hersch requested attendant care after November 6, 2007. A DWC-25 dated 10/30/07 noted that attendant care was recommended. Dr. Hersch did not include a recommendation for attendant care on any of the subsequent DWC-25s.

37. According to the adjuster's testimony attendant care was discontinued as of November 2, 2007 pursuant to Claimant's request. The evidence does not support a finding that additional days of attendant care were not provided because E/C misrepresented a material fact that the Claimant relied on to his detriment.

38. In Gauthier the JCC denied all benefits requested on the ground that all claims were barred by the statute of limitations. The claimant suffered a significant loss of vision in her right eye and all medical experts agreed she suffered a permanent impairment to some extent as a result of the compensable injury. The medical evidence demonstrated that she reached MMI on or before June 21, 2007. However, the E/C did not obtain the MMI date and impairment rating. When the claimant attempted to obtain medical treatment for an annual visit in August of 2008 E/C refused to authorize any further treatment because it determined the statute of limitations expired on claimant's case. Gauthier v. Florida International University, 38 So. 3d at 223. Claimant argued that E/C avoided payment of permanent impairment benefits **which, if paid, would have tolled the statute of limitations**. In reversing the JCC's denial of benefits the First District held that E/C was estopped from relying on a statute of limitations defense because claimant showed by uncontested evidence that the E/C failed to act when it was under a duty to do so and the claimant was misled to her detriment due to the E/C's omission. Id at 225.

39. The Gauthier court found that claimant's failure to file a PFB was due to the E/C's failure to convey accurate information concerning claimant's permanent impairment rating. Id.

40. The case at bar is distinguishable from Gauthier. The E/C obtained MMI information and provided that information to the Claimant. A DWC-4 dated July 23, 2008 explained that Claimant was placed at MMI on 6/10/2008 with a 1% permanent impairment rating, but that IIBs would not be paid because of the overpayment of temporary indemnity benefits. Even if the carrier paid IIB's taking a 20% reduction pursuant 440.15(12) Fla. Stat. (2007)[5] the statute of limitations

[5] Sec. 440.15(12) provides that if an employee has received a sum as an

would have expired prior to the filing of the petition for benefits nearly five years later.

41. E/C conceded that there were mistakes made in the handling of this claim, but there was no misrepresentation. E/C further asserted that a mistake is not sufficient to toll the statute of limitations and there is no evidence of detrimental reliance.

42. Sec. 440.192 Fla. Stat. (2007) provides, in part, that any employee may, for any benefit that is ripe, due, and owing file a petition for benefits. Therefore, pursuant to sec. 440.192 an employee should only file a petition when the E/C fails to provide a benefit that is ripe, due and owing. Sec. 440.19 (1) provides, in pertinent part, that all employee petitions for benefits under this chapter shall be barred unless the petition is filed within 2 years after the date on which the employee knew or should have known that the injury arose out of work performed in the course and scope of employment. Sec. 440.19(2) provides that payment of any indemnity benefit or the furnishing of remedial treatment, care, or attendance pursuant to either a notice of injury or a petition for benefits shall toll the limitations period set forth in sec. 440.19 (1) for 1 year from the date of such payment.

43. E/C's failure to provide a benefit that was ripe, due or owing is insufficient to toll the statute of limitations. If so, sec. 440.19 (1) would be pointless. Claimant must establish, at the very least, by a preponderance of the evidence, that E/C misrepresented a material fact, that Claimant relied on the misrepresentation, and as a result, Claimant changed position to his detriment. The evidence does not support a finding that E/C should be estopped from relying on the statute of limitations defense in this case.

WHEREFORE, IT IS ORDERED and ADJUDGED that:

1. The petition for benefits filed on June 18, 2013 is barred by the Statute of Limitations.

2. The claim for TTD/TPD from date of accident to present and continuing at correct compensation rate is DENIED.

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indemnity benefit under any classification or category of benefit under this chapter to which she or he is not entitled, the employee is liable to repay that sum to the employer or the carrier or to have that sum deducted from future benefits, regardless of the classification of benefits, payable to the employee under this chapter; however, a partial payment of the total repayment may not exceed 20 percent of the amount of the biweekly payment.

3. The claim for continued treatment with orthopedic or PCP for the right and left elbows is DENIED.

4. The claims for penalties, interest, attorney's fees and costs are DENIED.

5. Any issues not addressed herein are deemed denied.

6. Any objections not ruled upon are deemed overruled.[6]

DONE AND ORDERED this 21st day of March, 2014, in Lauderdale Lakes, Broward County, Florida.

Geraldine Hogan

Geraldine B. Hogan
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of the foregoing Order was furnished this 21st day of March, 2014 by electronic transmission to the parties' counsel of record, and by U.S. Mail to the parties.

Christie Sellers

Assistant to the Judge of Compensation Claims

COPIES FURNISHED:

Robert McNiven

[6] E/C's Exhibit #2 page 21:19 – 24 Objection sustained.
Claimant's Exhibit #1 page 16:9-12 Objection sustained.

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