



LUKS, SANTANIELLO PETRILLO & JONES

Our verdicts tell the story.

LEGAL UPDATE

VOLUME 11, ISSUE 4

OCTOBER — DECEMBER 2012

Liability

An Overview of Bad Faith Lawsuits in the State of Florida by Lysa Friedlieb,
Junior Partner.



Lysa Friedlieb

A person or a company purchases a one million dollar insurance policy, and an excess or umbrella policy for an additional five million dollars. A bad faith suit ripens when a case goes to trial and there is an award of monies in excess of the primary policy limits, and the primary insurance carrier failed to reasonably settle a case within its policy limits. Florida law is clear and has been consistent for thirty (30) years, that an excess carrier is entitled to maintain an action against a primary insurer based on the primary insurer's unreasonable refusal to settle a lawsuit within policy limits when it has affirmed the coverage of and has assumed the defense of such lawsuit.¹

The rationale behind the rule is that a person without excess coverage is in effect his own "excess" insurer. By purchasing excess coverage, he is insuring himself against the possibility of a judgment against him exceeding the primary policy's limits. When a judgment in excess of the primary policy limits occurs, the rights of the excess carrier against the primary carrier is identical to those that the insured himself would have had if he had not obtained the excess coverage.² Florida cases recognizing the right of an excess insurer to sue a primary insurer have stated that in a bad faith action the excess insurer "stands in the shoes of "the insured".³ The excess insurer thus has the same rights, as well as responsibilities, vis-a-vis the primary carrier that the insured would have if excess coverage did not exist.⁴ Thus, an excess insurer that is successful in a bad faith claim against a primary carrier is entitled to recover statutory attorney's fees just as an insured could do.⁵ Additionally, an insured's consent to try a lawsuit against it and the insured's agreement that the case should not be settled does not bar an excess carrier's bad faith suit against primary carrier alleging that the primary carrier unreasonably failed

Read More . . . P. 2

Verdicts and Summary Judgments

Appellate Division South

Doreen Lasch, Junior Partner of Luks, Santaniello, Petrillo & Jones obtained a decision from the Fourth District Court of Appeal on August 15, 2012 in a Trip and Fall case styled Sam Azoulay, as Personal Representative of the Estate of Renee Rosenberg v. Condominium Association of La Mer Estates, Inc. Plaintiff was injured when she tripped and fell over a parking bumper in the parking garage of her condominium. The jury awarded her medical expenses and \$300,000 in past and future pain and suffering. Upon defendant's motion for remittitur or new trial, the trial court remitted plaintiff's non-economic damages to \$150,000 based upon the court's finding that the plaintiff's

Read More . . . P. 11

INSIDE LEGAL UPDATE

An Overview of Bad Faith Lawsuits in the State of Florida P. 1
Does An Insurer Have a Duty to Assess and Investigate the Claim of an Insured within a Reasonable Period of Time. P. 5
Medicare Fines P. 8
Verdicts P. 1
Firm News P. 12

OFFICE LOCATIONS

MIAMI

T: 305.377.8900
F: 305.377.8901

FORT LAUDERDALE

T: 954.761.9900
F: 954.761.9940

TALLAHASSEE

T: 850.385.9901
F: 850.727.0233

PALM BEACH

T: 561.893.9088
F: 561.893.9048

ORLANDO

T: 407.540.9170
F: 407.540.9171

TAMPA

T: 813.226.0081
F: 813.226.0082

JACKSONVILLE

T: 904.791.9191
F: 904.791.9196

CLIENT RELATIONS

T: 954.762.7038

WWW.LS-LAW.COM

Edited by:

Maria Donnelly, CR
Daniel J. Santaniello, Esq.

An Overview of Bad Faith Lawsuits in the State of Florida cont.



Lysa Friedlieb

to settle case within its policy limits when it had opportunity to do so.⁶ When the policy gives the primary carrier full control of the litigation, including the right to determine whether case should be tried or settled, the insurer is required to exercise this authority in good faith, *regardless of insured's consent*, because the primary carrier has superior knowledge with regard to investigating, evaluating and adjusting the claim, and accordingly, the primary carrier is charged with acting reasonably under all circumstances and exercising due care with regard to settlements.⁷

A primary insurer has a duty to defend the insured in good faith and negotiate settlement, with an eye to protecting not only its own policy limits, but also those of the excess carrier and the insured's potential excess exposure. The primary carrier therefore, is not entitled to disregard the possibility of a judgment exceeding the primary limits, simply because there is excess insurance in place. Rather, the primary insurer, must treat the exposure of the excess policy limits in the same way as it would the insured's own assets, and that means taking reasonable, good faith steps to avoid or minimize the excess insurer's exposure. For example, if the court in an underlying matter ruled in favor of the plaintiff on his motion for summary judgment, and the primary carrier understands that the case will be tried on damages only, it has an affirmative duty to defend the suit and negotiate settlement. The primary carrier must retain experts to challenge plaintiff's damages so that it can effectuate an effective settlement posture or defend against the damages at trial.

Where liability and damages are sufficiently clear as to make a judgment in excess of the limits likely, then an insurer has an affirmative duty to initiate settlement discussions, even in the absence of a demand from the claimant.⁸ This means that a primary carrier may not simply sit back and await a settlement demand but must affirmatively attempt to settle the claim. Thus the primary carrier is not permitted to ignore the excess carrier's exposure in formulating its defense and settlement strategy, but is

required to evaluate the potential exposure in the case as though it alone would be responsible for the total liability.⁹ Hence, the fact that there is excess coverage in a case makes no difference with respect to the primary carrier's duty to attempt to avoid or minimize any exposure in excess of the primary limits.

The Primary Carrier's Fiduciary Duty to Act in the Insured's Best Interest

Pursuant to Boston Old Colony v. Insurance v., Gutierrez, 386 So. 2d 783, (Fla 1980) and its progeny, which includes Berges v. Infinity Insurance Co., 896 So. 2d 665 (Fla. 2005), it is the primary insurer's actions, its investigation, evaluation, and adjustment of the claim for the insured which are at issue in a bad faith action. The primary insurer's internal policies and procedures, computer notes on the matter, supervisory actions and the adjuster's attention to the case, or lack thereof, are all discoverable and at issue in a bad faith action. Evaluations of the case by defense counsel hired by the primary carrier are discoverable. The attorney-client privilege will not shield the discovery of this information in a bad faith action. The principles of bad faith followed in the State of Florida are set forth in the holding of Florida's Supreme Court case, Boston Old Colony v. Gutierrez, 386 So. 2d 783, 785 (Fla 1980) and are as follows:

- An insurer, in handling the defense of claims against its insured, has a duty to use the same degree of care and diligence as a person of ordinary care and diligence as a person of ordinary care and prudence should exercise in the management of his own business.
- When an insured has surrendered to the insurer all control over the handling of the claim, including all the decisions with respect to litigation and settlement, the insurer must assume a duty to exercise such control and make such decisions in good faith and with due regard for the interests of the insured.

Read More . . . P. 3

Bad Faith cont.

- The duty of good faith obligates an insurer to advise the insured of settlement opportunities, to advise as to the probable outcome of the litigation to warn of the possibility of an excess judgment and to advise the insured of any steps he might take to avoid the same.
- An insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonable prudent person, faced with the prospect of paying the total recovery, would do so.
- Since the duty of good faith involves diligence and care in the investigation and evaluation of claims against the insured, negligence is relevant to the question of the insurer's good faith.
- The question of an insurer's failure to act in good faith with due regard for the interests of the insured in the handling of claims against him is for the jury.
- "An insurer cannot escape liability for breach of duty of good faith by acting on what it considers to be its interests alone; an insurer with control over defense and settlement must at all times act in good faith, ..."

In the *Powell v. Prudential Property & Casualty Insurance Company*, the Court found that bad faith can be inferred from the delay and failure in settlement negotiations if delay is willful and without reasonable cause.¹⁰ An insurer has affirmative duty to initiate settlement negotiations, and the lack of a formal offer to settle will not preclude a finding of bad faith against a primary carrier.¹¹

An Excess Carrier's Equitable Right to Maintain a Bad Faith Action Against A Primary Carrier

The excess carrier has a right, in the absence of a contract or assignment from its insured, to maintain a cause of action under the equitable doctrine of subrogation for damages resulting from the primary carrier's bad faith refusal to settle a claim against their common insured.¹² In the *Ranger* case [excess carrier], Ranger sought to recover damages from

Travelers [primary carrier] based upon its contention that Travelers exercised bad faith in failing to settle a claim within Travelers primary policy limits. As a consequence of Travelers failure to settle the case within policy limits, Ranger became liable for and paid funds in settlement of the claim over and above the amount it otherwise would have had been required to pay.¹³ "The right of subrogation has been sustained in almost every conceivable type of action where a party invoking it has been required to pay a debt for which another is primarily answerable, and which equity and good conscience the other ought pay."¹⁴

The *Ranger* Court, citing the Supreme Court of Minnesota in the *Continental Casualty Company v. Reserve Insurance Company*¹⁵ affirmed the following duty the primary insurer owes to the excess carrier, "The threshold question is whether a primary insurer owes any duty to an excess carrier in the settlement negotiation process. It is clear that any liability insurer owes its insured a duty of good faith in deciding whether to accept or reject a settlement. This duty includes an obligation to view the situation as if there were no policy limits applicable to the claim, and to give equal consideration to the financial exposure of the insured."¹⁶

A breach of this duty by unreasonably rejecting an offer within the policy limits subjects the primary insurer to liability of its insured in the amount of the judgment in excess of the primary policy limits.¹⁷ The *Ranger* Court held that an excess carrier is subrogated to the insured's rights against a primary insurer for breach of the primary insurer's good faith duty to settle.¹⁸

Bad faith can be as simple as plaintiff's offer to settle for \$900,000, when it is a million dollar policy limit, and the adjuster evaluates the exposure from \$750,000 to \$1.2 million unreasonably rejects the settlement offer within policy limits, goes to trial and the jury awards \$1.8 million. The "bad faith" amount is then \$800,000 plus all the fees, interest and costs awarded to plaintiff in the underlying matter. Where the primary/excess relationship exists between the two insurers, the excess insurer stands in the shoes

Read More . . . P. 4

Bad Faith cont.



Lysa Friedlieb

of the insured with regard to insurer's duty to defend, which requires the insurer to investigate the facts and to make a good-faith offer to settle if a prudent person would do so.¹⁹ By way of the foregoing example, a prudent adjuster would settle within policy limits and not roll the dice with the excess carriers money, if a reasonable person determined through his/her investigation and evaluation of the case, that a \$1.2 million dollar verdict was not unreasonable.

Florida Does Not Recognize Comparative Bad Faith As An Affirmative Defense In Bad Faith Cases

At no time does the Boston Old Colony case and its progeny place at issue any of the excess carriers actions, policies or procedures. The King Court, declined to create a new affirmative defense of comparative bad faith when, in a bad faith claim, the primary insurer asserted an affirmative defense of comparative bad faith.²⁰ As long as the primary carrier does not tender its policy limits to the excess carrier to settle the suit, and does not reasonably settle the case within its policy limits, the excess carrier has no obligation to defend the suit or get involved in settlement negotiations as its policy is not triggered.²¹

For further information on Florida law and Bad Faith claims or assistance with your matters, please contact Lysa Friedlieb, Junior Partner in the West Palm Beach Office at T: 561.893.9088 or e-mail: LFriedlieb@LS-Law.com.

1. Ranger Ins. Co. v. Travelers Indem. Co., 389 So.2d 272 (Fla. 1st DCA 1980); Galen Health Care, Inc. v. American Cas. Co., 389 913 F. Supp. 1525 (M.D. Fla. 1996); Phoenix Ins. Co. v. Florida Farm Bur. Mut. Ins. Co., 558 So.2d 1048 (Fla. 2^d DCA 1990); North Am. Van Lines, Inc. v. Lexington Ins. Co., 678 So.2d 1325 (Fla. 4th DCA 1996), review denied, 692 So.2d 185 (Fla. 1997); General Accid. Fire & Life Assur. Corp. v. American Cas. Co., 390 So.2d 761 (Fla. 3^d DCA 1980), pet. For review denied, So.2d 1142 (Fla. 1981).
2. Ranger, 389 So.2d at 275.
3. Phoenix v. Florida Farm, 558 So.2d at 1050; Galen 913 F. Supp. at 1534.
4. Id.; also RLI Ins.Co. v. Scottsdale Ins. Co., 691 So.2d 1095 (Fla. 4th DCA 1997).
5. Aetna Ins. Co. v. Borrell-Bigby Elec. Co., 541 So.2d 139, 141 (Fla. 2nd DCA 1989); General Accid. v. American Cas., 390 So.2d at 766.
6. United States Fire Insurance Company v. Morrison Assurance Company, 600 So. 2d 1147, (Fla. 1st DCA 1992).
7. Id.
8. Powell v. Prudential Prop. & Cas. Ins. Co., 584 So.2d 12 (Fla. 3^d DCA 1991), review denied, 598 So.2d 77 (Fla. 1992); Self v. Allstate Ins. Co., 345 F. Supp. 191 (M.D. Fla. 1972); General Accid. v. American Cas., 390 So.2d at 761.
9. Boston Old Colony Ins. Co. v. Gutierrez, 386 So.2d 783 (Fla. 1980); North Am. Van Lines, 678 So.2d at 1331.
10. Powell v. Prudential Property & Casualty Insurance Company, 584 So. 12, (3rd DCA 1991).
11. Id. 584 So. 2d at 14.
12. Ranger Ins. Co. V. Travelers Indem. Co., 389 So.2d 272 (Fla. 1st DCA 1980). Galen Health Care, Inc. v. American Cas. Co., 389 913 F. Supp. 1525 (M.D. Fla. 1996); Phoenix Ins. Co. V. Florida Farm Bur. Mut. Ins. Co., 558 So.2d 1048 (Fla. 2^d DCA 1990); North Am. Van Lines, Inc. v. Lexington Ins. Co., 678 So.2d 1325 (Fla. 4th DCA 1996), review denied, 692 So.2d 185 (Fla. 1997); General Accid. Fire & Life Assur. Corp. v. American Cas. Co., 390 So.2d 761 (Fla. 3^d DCA 1980), pet. For review denied, So.2d 1142 (Fla. 1981); United States Fire Insurance Company v. Morrison Assurance Company, 600 So. 2d 1147, (Fla. 1st DCA 1992).
13. Id., 389 So. 2d at 273.
14. Id., 389 So. 2d at 273.
15. Continental Casualty Company v. Reserve Insurance Company, 238 N.W. 2d 862, 864 (Minn. 1976)
16. Id., 389 So. 2d at 275.
17. Id., 389 So. 2d at 275.
18. Id., 389 So. 2d at 275.
19. Phoenix Insurance Company v. Florida Farm Bureau Mutual Insurance Company, 558 So. 2d 1048, (2nd DCA 1990).
20. Nationwide Property & Casualty Insurance Company v. King, 568 So. 2d 990, (4th DCA 1990); Royal Indemnity Co v. Liberty Mutual Fire Ins., 2008 WL557963 (S.D. Fla.).
21. United States Fire Insurance Company v. Nationwide Mutual Insurance Company, 735 F. Supp. 1320, 1330 (U.S. E.D.N.C. 1990).

Does An Insurer Have A Duty to Investigate and Assess the Claim of an Insured within a Reasonable Period of Time? by Carl Christy, Junior Partner.



Carl Christy

In the matter of *QBE Insurance Corporation vs. Chalfonte Condominium Apartment Association*, decided by the Florida Supreme Court on May 31, 2012, this question was one of five submitted by the Eleventh Circuit Court of Appeals in Atlanta, Georgia

deemed by the Federal Appeals Court to be outcome determinative in a matter before it.¹

The first-party claim arose following Hurricane Wilma which struck Florida on October 24, 2005. The Chalfonte Condominium Apartment Association, Inc., hereinafter *Chalfonte*, located in Boca Raton, claimed damage as a result of the storm and filed an estimate of damages by December 18, 2005. On July 12, 2006 *Chalfonte* submitted a Sworn Proof of Loss and the same year, suit was filed in Federal Court in the Southern District of Florida (District Court).

In the District Court, *Chalfonte* raised claims for declaratory relief (Count I), breach of contract - failure to provide coverage (Count II), breach of contract – breach of the implied warranty of good faith and fair dealing (Count III), and violation of Florida Statutes Section 627.701(4)(a) (Count IV).

Count IV of the Complaint, violation of §627.701(4)(a) dealt with the statutory requirement that notice to policyholders regarding the deductible for hurricane losses must be in bold 18-point type and state: “This policy contains a separate deductible for hurricane losses, which may result in high out-of-pocket expenses to you.” The QBE policy substantially complied with the statutory requirement by including the required notice on the first page of the policy in all capital letters in a larger size font than the rest of the page. However, the notice was in 16.2-point instead of 18 point and referred to “windstorm” instead of “hurricane.” The District Court determined that Florida Statutes do not provide a cause of action for violation of §627.701(4)(a) and dismissed Count IV.

The remaining counts proceeded to trial and the jury found for *Chalfonte* on all of its claims awarding \$7,868,211 (including \$2,000,000 for Ordinance or

Law) for failure to provide coverage (Count II) and \$271,888.68 for breach of the implied warranty of good faith and fair dealing (Count III). The District Court also permitted the jury to deliberate on the Statutory violation. The jury concluded that the QBE policy did not comply with §627.701(4)(a). Post-trial, the District Court granted QBE’s Motion to reduce the \$8,140,099.68 judgment to take into account the policy windstorm deductible of \$1,605,653. The District Court awarded post-judgment interest and pre-judgment interest running from twenty days after *Chalfonte* submitted its Proof of Loss until the day Judgment was entered following trial. QBE filed a Notice of Appeal and the case went to the Eleventh Circuit in Atlanta.

The Eleventh Circuit certified five questions to the Florida Supreme Court after concluding that no Court in Florida addressed several key issues in the underlying action. Among the issues submitted to Florida’s highest Court was whether Florida law recognizes a claim for breach of the implied warranty of good faith and fair dealing by an insured against its insurer based on the insurer’s failure to investigate and assess the insured’s claim within a reasonable period of time.

A key component of the arguments made by *Chalfonte* during trial and at the appellate level was that Florida contract law recognizes an implied covenant of good faith and fair dealing in every contract. This covenant is intended to protect the “reasonable expectations of the contracting parties in light of their express agreement.”² The courts focused on whether this implied covenant applies to insurance policies and whether it is pre-empted or subsumed into Florida bad faith law.

The Florida Supreme Court reviewed the history of bad-faith in Florida noting that there was no first-party bad faith based in common-law³ and prior to the passage of the civil remedy statute⁴ in 1982, no statutory basis for bad faith either. The Court

[Read More . . . P. 6](#)

Does An Insurer Have A Duty to Investigate and Assess the Claim of an Insured within a Reasonable Period of Time cont.



Carl Christy

discussed cases decided by appeals courts within Florida which require that before a first-party bad-faith action can be brought, the coverage litigation must have concluded with a finding against the insurer. The Court discussed two Florida cases brought in Federal Court where the insured brought a claim against its insurer for breach of implied warranty of good faith and fair dealing claiming that the insurer failed to fairly and promptly investigate, pay, or settle the damage claim of the insured (not unlike the claims in *Chalfonte*).

In one instance, the case was dismissed in its entirety by a Federal Judge sitting in the Southern District of Florida who concluded that the claim for breach of the implied warranty of good faith and fair dealing was nothing more than a bad faith claim disguised as a breach of contract claim.⁵ In the other, also in the Southern District of Florida, the Court dismissed the count associated with breach of implied warranty of good faith and fair dealing holding that if it existed, it was premature and would be subsumed into a bad faith claim that might arise following resolution of the coverage dispute between the parties.⁶

In its analysis, Florida's highest Court noted that there are two limitations on claims arising from a purported breach of the covenant of good faith and fair dealings among contracting parties: (1) where application of the covenant would contravene the express terms of the agreement; and (2) where there is no accompanying action for breach of an express term of the contract.⁷ Significantly, the Florida Supreme Court noted a duty of good faith must "relate to the performance of an express term of the contract and not an abstract and independent term of a contract which may be asserted as a source of breach when all other terms have been performed pursuant to the contract requirements."⁸

Florida courts have determined that the implied covenant of good faith and fair dealing does not create a separate first-party action against an insurance company based upon its bad-faith refusal

to pay a claim.⁹ In fact, the Florida Supreme Court has specifically declined to adopt the doctrine of reasonable expectations in the context of insurance contracts concluding that construing insurance policies under this doctrine can only lead to uncertainty and unnecessary litigation.¹⁰ The Court pointed out that if policy provisions are ambiguous, the ambiguity is construed against the insurer. The Court emphasized that it is the policy terms which define insurance coverage and not the reasonable expectations of the insured.¹¹ Florida's highest Court stressed that such claims are actually statutory bad faith claims and must be brought under §624.155 Fla. Stat. (Florida's Civil Remedy Statute).

In the District Court, the jury determined that QBE violated the statutory requirement for font-size warning policy-holders of the separate deductible applicable to hurricanes. The District Court Judge ruled that even though the jury determined that the statute was not complied with, the hurricane (windstorm) deductible should be applied to the claim. *Chalfonte* argued that the finding of the jury should nullify the policy provision and the hurricane deductible should not be applied. *Chalfonte* urged the Appeals Court in Atlanta to reverse the ruling of the Judge in the District Court. The Appeals Court submitted this question to the Florida Supreme Court as well.

The Supreme Court disposed of this issue quickly concurring with the ruling of the District Court. It further observed that the plain language of the statute did not provide for either a penalty for violation or create a private cause of action. Florida's highest Court pointed to another section¹² in Florida Statutes governing insurance which expressly stated that in the absence of an express penalty, the courts should assume that a policy provision is valid despite noncompliance with the Insurance Code. The Court concluded that the Legislature is perfectly capable of crafting a penalty for violation of an insurance statute and the Court would not supply one.

[Read More . . . P. 7](#)

Does An Insurer Have A Duty to Investigate and Assess the Claim of an Insured within a Reasonable Period of Time cont.

On September 20, 2012 the Appeals Court in Atlanta published its final opinion based upon the input it received from the Florida Supreme Court. There will be a new trial of this matter and depending upon the outcome, there may be a subsequent bad-faith trial. In the first trial, the jury will not be permitted to hear evidence that QBE failed to timely investigate and assess the damages claimed by *Chalfont*. In addition, no evidence will be presented regarding claims that the hurricane deductible provision did not comply with Florida Statutes.

For further information on Florida law or assistance with your matters, please contact Carl Christy, Junior Partner in the Fort Lauderdale Office at T: 954.761.9900 or e-mail: CChristy@LS-Law.com.

1. QBE Insurance Corporation vs. Chalfonte Condominium Apartment Association, Inc., 2012WL1947863 (Fla.).
2. Barnes v. Burger King Corp., 932 F. Supp. 1420 (S.D. Fla. 1996).
3. Talat Enterprises, Inc. v. Aetna Casualty & Surety Company, 753 So. 2d 1278 (Fla. 2000).
4. Florida Statutes §624.155.
5. Portofino South Condominium Association of West Palm Beach, Inc. v. QBE Insurance Corporation, 664 F. Supp. 2d 1265 (S.D. Fla. 2009).
6. Nirvana Condominium Association, Inc. v. QBE Insurance Corporation, 589 F. Supp. 2d 1336 (S.D. Fla. 2009).
7. Insurance Concepts & Designs, Inc. v. Healthplan Services, Inc., 785 So. 2d 1232 (Fla. 4th DCA 2001).
8. Hospital Corporation of America v. Florida Medical Center, Inc., 710 So. 2d 573 (Fla. 4th DCA 1998).
9. Industrial Fire & Casualty Insurance Company v. Romer, 432 So. 2d 66 (Fla. 4th DCA 1983).
10. Deni Associates of Florida, Inc. v. State Farm Fire & Casualty Insurance Company, 711 So. 2d 1135 (Fla. 1998).
11. State Farm Fire & Casualty Insurance Company v. Castillo, 829 So. 2d 242 (Fla. 3rd DCA 2002).
12. §627.418 Florida Statutes.

About Carl Christy



Carl Christy

Carl Christy is a Junior Partner in the Fort Lauderdale office and has been practicing law for over a decade. Carl handles complex civil litigation matters in the areas of first party property, community associations directors and officers, construction defect matters, automobile and trucking liability, products & premises liability matters. Carl has represented a variety of clients including insurers, apartment complexes, landlords and property owners, commercial businesses and contractors on a wide range of disputes. Prior to his career in law, Carl held a CPCU and ARM designation serving in various claims positions within the Insurance industry. For further information about his article or assistance with your matters, please contact Carl Christy at T: 954.761.9900 or e-mail CChristy@LS-Law.com.

About Lysa Friedlieb



Lysa Friedlieb

Lysa Friedlieb is a Junior Partner in the West Palm Beach office. She was admitted in 1991, Florida and has more than 20 years of practice concentrating in construction defect, product liability, premises, vehicular, wrongful death, maritime law, commercial litigation, insurance coverage/bad faith, professional negligence and dispute resolution. Lysa has represented a variety of clients including insurers, construction companies, commercial contractors, community associations, apartment complexes, landlords and property owners, commercial businesses, major cruise lines and airline companies on a wide range of complex civil litigation matters. For further information on Florida law and Bad Faith claims or assistance with your matters, please contact Lysa Friedlieb, Junior Partner in the West Palm Beach Office at T: 561.893.9088 or e-mail: LFriedlieb@LS-Law.com.

Medicare's Failure to Communicate Fines for Failure to Comply. Who Is Responsible and How Much Are the Fines?



Rey Alvarez

“What we have here is...failure to communicate”, one of the memorable movie lines of all time from the 1967 movie, Cool Hand Luke, starring Paul Newman. In 2012, it may also be the best way to describe Medicare's handling of the Medicare Secondary Payer statute. Not

following Medicare's complex and difficult to understand requirements can lead to heavy fines and penalties. Medicare has not done the job of communicating their message. This article will address the various penalties and fines that can be assessed for failure to comply.

We all know the bad news. Medicare is in dire financial straits. Fraud appears to be an everyday occurrence. There is always some amazing story about how a company bilked the Medicare system out of millions of dollars. The system itself lacked checks and balances and has been mismanaged.

However, while the news likes to report about the negative, Medicare is at least trying to make strides in straightening the ship. They have gone after people who are committing the fraud. They have established a group that goes after folks that get creative in their billing. Besides fraudulent and over payment issues, over the past ten years or so, Medicare has addressed their status as a secondary payer when it came to the settlement of claims where there was a primary payer.

The law clearly states that Medicare is a secondary payer when there is another payer that is primary. Since 1965, Workers' Compensation has been a primary payer over Medicare. However, Medicare did not really attempt to collect settlement monies designed to cover future Medicare medical needs until 2001. Liability insurance has been a primary payer since 1985, but it has not been until the present that Medicare appears to be showing some interest in collecting settlement monies designed to cover future Medicare covered medical needs.

The avenue that Medicare is using to go after the settlement monies is the Medicare Secondary Payer Act. The basic intent behind the Medicare Secondary

Payer Act is to ensure that their interests are protected in any settlement. The Act gives Medicare the authority, responsibility and duty to ensure that their interests are protected when another primary payer is responsible. Is the system that Medicare currently has in place adequate, some will agree, others will not. However, whether we agree or disagree, that is the current state of affairs when it comes to dealing with claims involving an individual that gets hurt.

In order to ensure that all entities follow the Medicare Secondary Payer statute, Medicare has placed numerous penalties and fines into the statute. The first thing that needs to be understood is that the current Medicare structure is broken into 3 different but yet combined sections. Each of the three sections has its own 'rules' and penalties for not adhering to the rules. Some of the penalties have 'teeth' while others do not. At times all three sections will need to be addressed and at other times, maybe one or no sections will need to be addressed.

The three sections are: **1. Section 111; 2. Conditional Payments; and 3. Future Medicare covered medical needs.**

Section 111

Section 111 deals with the mandatory reporting of a claim involving an injured party. Section 111 mandates that all cases involving a Medicare beneficiary need to be reported to the Centers for Medicare and Medicaid Services (CMS). In addition, as the case progresses, additional information needs to be submitted to CMS. Likewise, all settlements need to be reported. Section 111 is only for Medicare beneficiaries.

It is easy to determine when a claimant is a Medicare beneficiary due to age, but it is not always easy to determine a Medicare beneficiary who is on Medicare for other reasons. Further research needs to be done on all cases that get reported to ensure compliance with Section 111.

[Read More . . . P. 9](#)

Medicare cont.

Section 111 Fine

For each unreported claim, a Section 111 Responsible Reporting Entity (not the claimant or his attorney) "shall be subject to a civil money penalty of \$1,000 for each day of noncompliance with respect to each claimant.

It does not appear that CMS has levied this fine on any Responsible Reporting Entity as of the publication date of this Legal Update. Not reporting just one claim for a month can cost a Responsible Reporting Entity approximately \$30,000. A claim that is reported and rejected because of insufficient or missing data could be subject to the same penalties as a claim that was never submitted.

Conditional Payments

According to 42 CFR 411.21 conditional payments are payments that Medicare has made for services for which another payer is responsible, with the expectation that Medicare will get repaid. This fine has the most teeth and has been put in place time over time.

42 CFR 411.21 defines a primary payer as any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.

The **Conditional Payment Fine** is the responsibility of the primary payer. In Workers' Compensation it is usually resolved by the carrier. In liability, it is usually resolved by the plaintiff. Nevertheless at the end of the day, it is the **responsibility of the primary payer. Fines consist of interest and may lead up to "double damages" should Medicare take legal action.**

U.S.C. 1395y(2)(b) Repayment of conditional payment is required. "An entity that receives payment from a primary plan, shall reimburse the appropriate

Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service."

The section goes on to read that "A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."

Here comes the fine. If reimbursement is not made within 60 days of the initial notice, interest begins accruing and continues to accrue until the reimbursement is made.

The section goes on to read that if Medicare has to bring legal action "against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan, the United States **may, in accordance with paragraph (3)(A) collect double damages against any such entity.**"

Future Medicare Covered Medical Needs

Surprisingly, the Medicare Secondary Payer Act does not address future Medicare covered medical needs when it discusses fine and/or penalties. Attorneys and insurance companies have spent countless hours debating the need for Medicare Set Asides. Both sides have good points. Unfortunately, except under Workers' Compensation, Medicare has not given any assistance with respect to future medical needs.

In Workers' Compensation, Medicare Set-Asides have been in place since 2001.

Read More . . . P. 10

Medicare cont.

42 CFR 411.22 reads that a primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any payment if it is demonstrated that the primary payer has or had a responsibility to make payment.

When 42 CFR 411.21 is read in conjunction with 42 CFR 411.22 a very compelling argument can be made that settlement monies extended to a plaintiff in a settlement is really an extension of primary payer money. Basically, if a plaintiff gets a monetary settlement, the money he gets can be viewed as primary payer money that is simply changing hands. The plaintiff, under 42 CFR 411.22 is now the primary payer. Hence, if Medicare makes a payment, the payment will be viewed as a conditional payment and will be subject to the fines and penalties discussed in the conditional payment section.

In the Workers' Compensation setting there is a vague penalty of denial of future benefits if the monies allocated for Medicare are not used for Medicare covered medical needs as it relates to the injuries.

As you can see, a single case can be hit with penalties from all sides. The entity that is responsible can also be different depending on the reason for the penalty. It is important to know how and when penalties can be assessed as they can add up quickly.

For further information on Medicare fines for failure to comply or assistance with your matters, please contact Rey Alvarez, Managing Attorney in the Miami Office at T: 305.377.9900 or e-mail: RALvarez@LS-Law.com.

This Legal Update is for informational purposes only and does not constitute legal advice. Reviewing this information does not create an attorney-client relationship. Sending an e-mail to Luks, Santaniello et al does not establish an attorney-client relationship unless the firm has in fact acknowledged and agreed to the same.

Workers' Compensation Case Law Blog Site

<http://floridaworkerscomp.blogspot.com>



Rey Alvarez

Follow **Rey Alvarez**, Managing Attorney and his discussion of current Workers' Compensation case law and important decisions at his WC blog site. Visitors may view cases by the judge or the topic. A copy of the First District Court of Appeal (1DCA) opinion is a click away on the site. For local and national Workers' Compensation news, follow Rey Alvarez on twitter @reyalvarez.

The firm's Medicare Compliance Practice under Rey Alvarez offers nationwide services for Medicare Set-Asides, Medicare Conditional Lien Negotiation, Medicare Reporting and Risk Analysis Services. Rey has more than a decade of experience in preparing Medical Cost Projections, Medicare Set-Asides and Conditional Payment Lien negotiations with CMS. Rey co-authored a White Paper on Medicare Reporting that was published in the Trial Advocate Quarterly (i.e., Volume 30, Number 4, Fall 2011). Rey also authored an article on "Reducing the Cost of Funding a Medicare Set-Aside" that was published in the Florida Bar Workers' Compensation Section 'News & 440 Report' (Summer 2011).

Rey is a member of the Florida Defense Lawyer's Association (FDLA) and Claims & Litigation Management Alliance (CLM). Rey works out of the Miami office located on 150 West Flagler Street. For assistance with future medical cost projections, evaluation and reduction of conditional payments or settlement value and exposure and non-covered allocations (non-Medicare covered medical services and treatments), please contact Rey Alvarez at T: 305.377.9900 or e-mail RALvarez@LS-Law.com.

Verdicts and Summary Judgments

evidence on pain and suffering was scant and not in support of such an award. Emphasizing "the intent of the Legislature to vest the trial courts of this state with the discretionary authority to review the amounts of damages awarded by a trier of fact in light of a standard of excessiveness or inadequacy" (quoting Fla. Stat. 768.74(6)), the appellate court concluded that the trial court exercised its authority in this case, and finding no clear abuse of discretion, affirmed the remittitur.

Appellate Division South

Doreen Lasch, Junior Partner of Luks, Santaniello, Petrillo & Jones obtained an affirmance by the Fourth District Court of Appeal in the case styled Mazoff v. Alamo Financing, L.P. The appellate court entered its opinion in favor of our client Alamo On October 10, 2012, in which the appellate court affirmed a final summary judgment entered in favor of Alamo by the trial court. The case involved a two car accident in which one car overturned. The accident occurred on 4/22/2007 on the Florida Turnpike at MM 61 in Tamarac, Broward County. Matthew Mazoff was one of two Good Samaritans trying to assist occupants of the overturned vehicle. The rental vehicle approached the scene and struck the overturned vehicle causing it to roll over and pin the two Good Samaritans, resulting in severe injuries to both plaintiff's legs. The basis of the appellate opinion was the Federal Graves Act which eliminated vicarious liability of rental car companies for damages caused by the negligence of renter/drivers of the rental cars.

Jacksonville Office

Todd Springer, Junior Partner of the Jacksonville office of Luks, Santaniello, Petrillo & Jones obtained a summary judgment in a premises liability case styled Charles D. Ramsey and Gudrun Ramsey v. Home Depot U.S.A., Inc. and John Markham Newbern, in Escambia County on October 15, 2012. The case involved a trip and fall incident which occurred on March 12, 2009. On that date, Ms. Ramsey tripped on a concrete wheel stop located in a handicapped parking space where she had parked her car in the Home Depot parking lot. Plaintiff alleged that she did not see the wheel stop but did see the cement bollard encasing the bottom portion

of the handicapped sign. Plaintiff further alleged that the configuration of the parking space with both the cement bollard and the wheel stop was redundant and unnecessary thereby creating a dangerous condition. It was the Defense's position that the concrete wheel stop was an open and obvious condition which one would reasonably expect to find in the front center of a parking space and could be seen by a reasonably prudent person. The Court granted the Motion for Summary Judgment finding that the wheel stop was readily observable by any person using reasonable care as it was an open and obvious condition.

New EUO Condition - Florida Motor Vehicle No-Fault Law.

Given the new EUO condition precedent to coverage that is effective January 1, 2013, we'd like to assist with your matters. The Law Alert by Andrew Chiera, Esq., and Daniel Fox, Esq., distributed in March 2012 on the Florida Motor Vehicle No-Fault Law is available on the home page at www.LS-Law.com. For answers to questions regarding the law or assistance with PIP matters and EUOs, please contact:



Andrew Chiera, Esq.
West Palm Beach Office
T: 561.893.9088
E: AChiera@LS-Law.com



Daniel Fox, Esq.
Miami Office
T: 305.377.8900
E: DFox@LS-Law.com



Kate Kmiec, Esq.
Orlando Office
T: 407.540.9170
E: KKmiec@LS-Law.com



Kelly Klein, Esq.
Tampa Office
T: 813.226.0081
E: KKKlein@LS-Law.com

FIRM NEWS

Daniel Santaniello Named President-Elect FDLA



Daniel Santaniello

Daniel Santaniello, Managing Partner of Luks, Santaniello, Petrillo & Jones has been named President-Elect for 2012-2013 of the Florida Defense Lawyers Association (FDLA). He accepted his nomination on August 11, 2012 at the FDLA's annual meeting in Amelia Island, Florida.

The Florida Defense Lawyers Association is comprised of more than 1000 members that are attorneys in private practice, employed by public agencies and private corporations. The FDLA provides continuing legal education programs, development, networking and support to its members. Daniel Santaniello previously served as the FDLA Secretary-Treasurer from 2011-2012 and has served on the FDLA's Board of Directors since 2007. He was also the recipient of the FDLA's President's Award in 2010 for outstanding service.

Mr. Santaniello is Board Certified in Civil Trial by The Florida Bar and AV® Preeminent™ 5.0 out of 5, Peer Review Rated by Martindale-Hubbell. Daniel was selected to the Florida Super Lawyers in 2012 and 2011. He was also selected by the Daily Business Review as Most Effective Lawyer (Finalist, 2007), along with Paul Jones, Orlando Partner and James Waczewski, Tallahassee Partner for their innovation in filing a Declaratory Judgment Action in a multiple Wrongful Death claim.

Daniel Santaniello is a Founding Partner of the firm, which he started in 1995 with Jack Luks, Partner. He is a graduate of Nova Southeastern University Law School, *summa cum laude* (Class Rank 3rd, 1990). Mr. Santaniello handles highly publicized cases in the areas of Wrongful Death, Auto and Trucking, Premises, Product Liability, Toxic Tort, Construction and General Liability. Over the last 20 years, he has tried numerous high exposure cases to verdict and led the firm's Litigation practice. For additional information about Daniel Santaniello, please visit www.LS-Law.com.

The Kind of Talent That You Have Come to Expect!

Congratulations to our attorneys for recently obtaining the distinction of an **AV® Preeminent™** Rating from Martindale-Hubbell. Colleagues made up of members of the bar and the judiciary evaluated and ranked our attorneys at the highest level of professional excellence. **AV® Preeminent™** is the highest rating available for legal ability and professional ethics. Visit Martindale.com for Ratings information.



Heather Calhoon

Miami Office Managing Partner
T: 305.377.8900
E: HCalhoon@LS-Law.com



Anthony Merendino

Junior Partner W. Palm Beach Office
T: 561.893.9088
E: AMerendino@LS-Law.com



Thomas Farrell

Junior Partner Orlando Office
T: 407.540.9170
E: TFarrell@LS-Law.com



AV® Preeminent™ and BV® Distinguished™ are certification marks of Reed Elsevier Properties Inc., used in accordance with the Martindale-Hubbell certification procedures, standards and policies."