STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS
OFFICE OF THE JUDGES OF COMPENSATION CLAIMS
ORLANDO DISTRICT OFFICE

Paul Behrig,
Employee/Claimant,

vs.

Brevard County Board of County Commissioners/Preferred Governmental Claims Solutions/PGCS,
Employer/Carrier/Servicing Agent.
_____/

OJCC Case No. 24-022041JEJ

Accident date: 05/08/2024

Judge: Jill E. Jacobs

FINAL COMPENSATION ORDER

THIS CAUSE came on for a Final Merits' Hearing before the undersigned Judge of Compensation Claims on July 21, 2025, on the Petition for Benefits filed on January 21, 2025. A mediation conference was held on June 5, 2025. The joint pretrial stipulation was filed on June 18, 2025. Paul Behrig (or Claimant), was present and represented by Kristine Callagy, Esquire. Derrick E. Cox, Esquire was present on behalf of the Employer/Carrier/Servicing Agent (E/C/SA), Brevard County Board of County Commissioners/Preferred Governmental Claims Solutions/PGCS. Accompanying Mr. Cox was a summer associate for HR Law, Marylin Shandor. The claimant, Paul Behrig, appeared via Zoom. Live testimony was taken from Paul Behrig. The record closed on July 21, 2025.

RELEVANT STIPULATIONS

As reflected in the parties' joint pretrial stipulation, they agree to the date of the annual Life Scan evaluation, May 8, 2024, as the date of accident; that this occurred in Brevard County, so venue is proper in the Orlando district. There was an employment relationship on that date, and workers' compensation insurance coverage. The parties stipulate that the OJCC has jurisdiction over the parties and the subject matter herein. They agree that the average weekly wage is $2,359.62, with a corresponding compensation rate of $1,260.00, which is the maximum for 2024.

The E/C/SA agree to authenticity and admissibility of the pre-employment physical, payroll records, and 13-week wage statement, all previously provided.

OVERVIEW/ISSUES FOR CONSIDERATION[1]

The Claimant, Paul Behrig, is a lieutenant with the Brevard County Fire Service. He seeks compensability of his cardiomyopathy pursuant to §112.18(1), Florida Statutes; authorization and provision of medical care and treatment with a cardiologist; temporary total disability (TTD)

[1] The claims, defenses, affirmative defenses and avoidances from the pretrial are listed in Appendix 1, attached.

benefits from May 8, 2024, through June 21, 2024[2]; interest and penalties on the TTD; and attorney's fees and costs.

On the pretrial, the Claimant avoids the affirmative defense by objecting to the opinions and testimony given by the E/C/SA's IME regarding causation, pursuant to §90.702, Florida Statutes, and *Daubert v. Merrell Dow Pharmaceuticals, Inc*., 509 U.S. 579 (1993), and related line of cases. The E/C/SA asserts the same objections to the Claimant's IME. Neither party filed a *Motion in Limine*, nor otherwise requested ruling as to *Daubert.*

The E/C/SA have denied compensability of the claim, asserting the Claimant has not established entitlement to the presumption; specifically, that these two prongs have not been met: (1) the Claimant's condition does not meet the definition of "heart disease" under the authority of *North Collier Fire Control and Rescue District/PGCS*, 371 So. 3d 368 (Fla. 1st DCA 2023); and (2) that the Claimant has not proven disability because he only underwent diagnostic testing, is working full time and is not disabled.[3] E/C/SA assert alternatively that if it is found that the Claimant is entitled to the presumption, there is competent, substantial evidence to rebut the presumption. E/C/SA raise as an additional defense that the Claimant's wage loss is unrelated to a work-related accident or injury. As he is working full time for the employer, no TTD is owed. There are no penalties, interest, costs or attorney's fees due.

For the reasons set forth below, I find the Claimant, Paul Behrig, is entitled to the presumption of causation afforded pursuant to §112.18, Florida Statutes, and that same has not been rebutted.

DOCUMENTARY EXHIBITS

All documentary exhibits are listed on the attached Appendix I, along with any objections and rulings thereon.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

In making my findings of fact and conclusions of law, I have observed the candor and demeanor of the witnesses who testified live before me, and resolved all the conflicts in the testimony. Although I may not reference or detail each item of evidence presented by the parties, I have analyzed all the evidence and exhibits in the context of the arguments of counsel and appropriate statutory authority and case law in making these findings of fact and conclusions of law. *See* §440.25(4)(e), Florida Statutes; *Garcia v. Fence Masters, Inc*., 16 So. 3d 200 (Fla. 1st DCA 2009) (holding that a compensation order need only contain findings of ultimate material fact necessary to support mandate, rather than a recitation of all evidence presented).

I have jurisdiction over the parties and the subject matter of this claim. I accept the parties' stipulations and incorporate them by reference herein. Pursuant to the provisions of §440.015,

[2] The claimant through counsel announced, at the start of the hearing, that TTD sought was being reduced, from "and continuing" to a fixed, 45-day period, from May 8, 2024, to June 21, 2024; and the claim for TPD was withdrawn.
[3] In other words, the E/C/SA agree that the claimant has met the first two prongs, a clean bill upon entering the fire service, and he was a covered employee on the date of accident.

Florida Statutes, I have not interpreted the facts in this case liberally in favor of either the rights of the injured worker or the rights of the employer. I have construed the law in accordance with the basic principles of statutory construction.

Any and all issues raised by way of the Petition for Benefits that are subject matter of the final hearing, but which issues were not dismissed or tried at the hearing, are presumed resolved, or in the alternative, deemed abandoned by the Claimant, and therefore are denied and dismissed with prejudice. See *Scotty's Hardware v. Northcutt*, 883 So.2d 859 (Fla. 1st DCA 2004); *Betancourt v. Sears Roebuck & Co*., 693 So.2d 860 (Fla. 1st DCA 1997). Any objections made in the depositions offered, but not brought to my attention, are overruled.

Summary of the Evidence

Paul Behrig, the claimant, testified live via Zoom before me. I found him to be credible and accept his testimony. He entered the fire service in 2004, and has been employed continuously for Brevard County Board of County Commissioners (Brevard BOCC). He has achieved the rank of lieutenant. At the time of his hire, he underwent a physical examination, which he passed; i.e. he was designated as being able to perform all functions of the job of firefighter. On May 8, 2004, while undergoing the required annual physical through Life Scan, it was his understanding that the ultrasound conducted revealed a lower than normal ejection fraction. The working diagnosis at that time was cardiomyopathy. The examination was suspended by the technician, and Lt. Behrig understood he would not be released to return to work until he was cleared by a cardiologist.

He saw his personal cardiologist, Dr. Isaac Dor, who directed his care. Dr. Dor conducted a more thorough examination with an echocardiogram, and confirmed the diagnosis of cardiomyopathy. The doctor prescribed medications for the cardiomyopathy, and simultaneously ordered additional testing. The claimant's understanding of the testing was that it was to determine if there was an underlying cause for the cardiomyopathy that would need to be treated, such as a viral infection, a genetic abnormality, or blockages from coronary artery disease.[4] He followed the doctor's orders, and underwent the testing and procedures. The genetic testing failed to reveal any abnormality, and the cardiac catheterization likewise showed no atherosclerosis.

The claimant testified that Dr. Dor would not sign off on his return to work until the claimant had least one month on the new medications, which the claimant identified as Entresto for the cardiac output, Metoprolol and Spironolactone.

Dr. Dor did periodic updated testing of his heart's functioning, and was satisfied with his "numbers" (ejection fraction) after about 6 weeks. Lt. Behrig was released to full duty work effective June 22, 2024. He has remained on the new heart medications, and his understanding is that he will have to be on them for the rest of his life.

[4] During the claimant's direct examination, counsel for E/C/SA objected to multiple questions on grounds of form ("calls for a medical conclusion"). These questions pertained to what happened during his office visits with Dr. Dor. In overruling the objections, I found that a reasonable person could understand and explain what took place at a medical appointment, without being a physician.

On cross-examination, Lt. Behrig testified that he felt fine on the day of the annual examination, and remained without symptoms during the six weeks he was taken off work. He was questioned about going back to playing pickleball, which he returned to after being released to work.

Steven Borzak, M.D., the claimant's IME, testified by deposition taken June 11, 2025 (C-4). His report memorializing his records review IME was attached to the deposition, and dated January 20, 2025. Dr. Borzak reviewed the pre-employment physical and found no evidence of hypertension or heart disease on April 20, 2004. He reviewed the claimant's cardiac history and testified that *"He was found on an annual examination to have an abnormal cardiac ultrasound and was referred for further evaluation. He was found to have a non-ischemic idiopathic dilated cardiomyopathy and underwent treatment with a cardiologist, Dr. Dor."* (C-4, p. 9). The claimant's diagnosis as a result of the event on May 8, 2024, was cardiomyopathy.

As to whether cardiomyopathy is heart disease, Dr. Borzak testified as follows:

Q. And is cardiomyopathy a heart disease?
A. Yes.
Q. Okay, perfect. And how long has cardiomyopathy been deemed a heart disease in the cardiology community?
A. I don't know, but certainly well in advance of my career beginning.
Q. Okay. Fair enough. And is cardiomyopathy a structural abnormality in the heart or is it considered a functional abnormality?
A. It's a structural problem with the left ventricle, the pumping chamber of the heart.

Dr. Borzak testified that in his opinion, the claimant suffered an impairment of health as a result of the cardiomyopathy on May 8, 2024. He explained that the annual examination often includes ultrasound in addition to a physical exam, stress test, and other testing. *"In his case the screening ultrasound showed that myocardial performance, the heart muscle, seemed to have diminished pumping activity with a low ejection fraction as well as dilation enlargement."* (C-4, pp. 10-11). The claimant was then referred to a cardiologist for further evaluation, where he had what Dr. Borzak referred to as a "true echocardiogram", which confirmed the findings and demonstrated an impaired ejection fraction and left ventricular dilatation. He explained that *"Cardiomyopathy affects the heart's normal function. It's a decreased performance of the heart. The contractility, the pumping function, the action is diminished and it leads to -- can -- can lead to symptoms as well as progression of the heart failure syndrome."* (C-4, p.12).

As far as whether cardiomyopathy originates in the heart, the doctor testified that it is called "idiopathic" because it is not always clear. A number of cases arise from non-recognized viral infections, but doctors do not generally seek a cause other than to exclude coronary artery disease, which itself requires treatment. With a viral genome, the original infection could have occurred long before any manifestation of the cardiomyopathy.

According to Dr. Borzak, *"cardiomyopathy directly affects the heart muscle, weakening it."* With the following testimony Dr. Borzak explained in more detail the damage to the heart that

can be caused:

Q. Okay. And so cardiomyopathy then can cause damage to the heart muscle, it sounds like?

A. ***Cardiomyopathy is by definition damage to the heart muscle, cardio - heart, myo - muscle, pathy - disease****. Further, pulmonary hypertension can sometimes occur secondarily as a consequence of left ventricular impairment.* ***Cardiomyopathy can create an increased risk for heart failure.***
(Emphasis added).
…….

A. It -- it can vary, but the current understanding is that the muscle contractility is diminished and an adaptive mechanism in order to preserve stroke volume, that is the amount of blood that's sent out with each heartbeat, is that the heart then starts to stretch or dilate. And this means that with less effort, the same stroke volume can go forward at a lower ejection fraction. Ultimately, though we learned that left ventricular dilatation leads to worsening performance and further dilatation and is part of the vicious cycle of heart failure progression. And so our strategies have developed to produce interventions, which will blunt or eliminate left ventricular enlargement or hopefully in some cases, reverse it.

Dr. Borzak did not feel that the claimant had symptoms of heart failure. Based on the records he had, claimant has **asymptomatic left ventricular dysfunction**. By some classifications, that would be considered an early stage of heart failure under the newer classification. However, according to the New York Heart Association Symptom Classifications, the claimant is functional Class I and seems to be asymptomatic. (C-4, pp. 14-15). Emphasis added.

In Dr. Borzak's opinion the claimant was disabled due to heart disease on May 8, 2024, as he was told he could not work as a firefighter until further evaluated. As far as whether it was safe for the claimant to continue working during that time, until cleared, that is addressed *"only in retrospect****. But at the time it was unclear what the implications of this preliminary finding were. So it was reasonable to take him off of work for further evaluation***." (C-4, p.17). Emphasis added.

With respect to future medical care, the claimant will need regular visits with cardiologists, at least three or four times a year, with evidence-based medical therapy, including the medications he is already receiving. Additionally, echocardiograms at various intervals depending on how he is doing, perhaps annually. (C-4, p. 18).

The claimant has not yet reached MMI. To get to that point, Dr. Borzak explained that with the diagnosis of cardiomyopathy, *"the process is to initiate evidence-based therapy, which Dr. Dor has undertaken. And then to adjust the doses of that medicine to maximum tolerated or towards the goal, depending on the specific therapy. And then at some point re-image to see if ventricular performance has improved and if [the] left ventricular size has regressed. So, I would expect that process would take at least six months, but probably longer."*

On cross-examination, Dr. Borzak explained the difference between the more cursory general ultrasound done during the Life Scan annual, as opposed to what a cardiologist would order and interpret, i.e. an echocardiogram, which is a dedicated, detailed cardiac examination involving two-dimensional imaging as well as Doppler echocardiography. Nonetheless, the technician did identify an abnormality.

As to the cardiac catheterization, the purpose of this test was to "exclude coronary disease, not to confirm the cardiomyopathy diagnosis. Though it did." (C-4, p. 24).

As to the claimant's incapacity during the 6 weeks at issue, Dr. Borzak testified: *"So on the date of accident he was disabled because of abnormal findings. My opinion is that that was a very reasonable measure because he needed further evaluation and initiation of treatment. As far as his return to work, his treating cardiologists chose June 21st of '24. And I can't form an opinion as to whether that's appropriate or not. I have no reason to say that it's not, but I can't endorse it either."* (C-4, p. 27).

Dr. Borzak reiterated he found it reasonable that the claimant not work after the abnormality was found on May 8, 2024, and to remain out of work until the echocardiogram and catheterization were complete. As seen in this dialogue between Dr. Borzak and Mr. Cox:

Q. But none of the -- not -- neither the diagnostic catheterization or the echocardiogram performed on May 15th showed anything other than what your understanding was that showed up on the date of the accident of May 8th, which was that he had a low ejection fraction, correct?

A. Right.

Q. And is it your understanding that that one finding has been consistent throughout?

A. Yes.

Q. So either he's able to work with this finding, or he's not able to work with this finding, that's the question and you cannot answer that question as we sit here today, correct?

A. Well, it's not that simple because at the time that it was identified on May 8th, nothing was known and he was not on any treatment. Once he saw the cardiologist, underwent further evaluation, including a cath to exclude coronary disease and was started on treatment, he was then seen -- evaluated after initiation of treatment and return to work. So his state on June 21st is much different that it was identified on May 8th.

Dr. Borzak was then questioned about the *Harlem*[5] case. The doctor was familiar with it, had read it, and recalled that it involves only the coronary arteries, heart muscle, and valves, but excludes electrical abnormalities.

Q. Do you agree that the claimant in this case does not meet that Harlem definition of heart disease since he has no -- since he has no evidence of ischemia found on the catheterization?

A. Again, I don't have the Harlem decision in front of me, but I think they included

[5] *North Collier Fire Control and Rescue District vs. Harlem*, 371 So.3d 368 (Fla. 1st DCA 2023).

heart muscle disease, which is what he has. ..... In any case, I would -- I wouldn't ask a -- an appellate judge whether someone has heart disease or not; I would ask a cardiologist."
(C-4, p. 32 lines 21-25; p. 33, lines 1-16).

On redirect examination, claimant established that the genetic testing ruled out any inherited genes, mutations, for inherited cardiomyopathies. As to *Harlem*, the claimant had the doctor clarify his response.

Q. Okay. Thank you. And last question, Doctor, I want to touch back on the definition of heart disease in Harlem that Derrick was asking you about. The way it's written in the case says, basically it is "the type of disease affecting and weakening the heart muscle through a degradation of the vessels or the valves and which was prevalent as a major cause of death in the United States in the 1950s and the 1960s." Does cardiomyopathy fit that definition?

A. I think cardiomyopathy was a major cause of death in the 1950s and the 1960s. And still today the majority of cases of cardiomyopathy are caused by coronary disease. But that proportion has gone from roughly three quarters down to maybe 60 percent. So the contribution of coronary disease has diminished, but it -- and it still remains the -- the main cause of cardiomyopathy, but it's not the only cause.

Q. Okay. And is it still your opinion that cardiomyopathy weakens the heart muscle?

A. Yes.

Amish Parikh, M.D., E/C/SA's IME, testified by deposition taken June 25, 2025 (E/C/SA-1). Dr. Parikh evaluated Paul Behrig in June 9, 2025. History was given, and the doctor reviewed records of Dr. Dor, and the catheterization results, which were normal, with no atherosclerosis. Dr. Parikh testified consistently with Dr. Borzak, diagnosing the claimant with idiopathic cardiomyopathy. Likewise, Dr. Parikh did not find hypertension. He referenced CHF or congestive heart failure, which is a type of cardiomyopathy, and which is idiopathic.

Dr. Parikh did find the claimant had reached MMI on the June 9, 2025, IME evaluation. He assessed a Class I impairment rating of 5% for the cardiomyopathy. (E/C/SA-1, p. 11). Mr. Cox then addressed the *Harlem* and *Bivens*[6] cases with Dr. Parikh:

Q. And Doctor, I -- prior to your deposition, provided a couple of cases that I wanted to ask you about. The -- and I don't know if you had a chance to review them, but the first case is North Collier Fire Control and Rescue District v. Harlem, and in that case, the Court discusses a very specific definition of heart disease, and in that case, it limited heart disease to essentially the atherosclerosis, you know, narrowing of arteries.

A. Right.

Q. Did you have a chance to look at that case and that –

A. Yes. Yes.

Q. Okay. And based on the definition of heart disease as outlined in the Harlem case, does the claimant in this case have heart disease by that definition contained in that case?

[6] *Bivens v. City of Lakeland*, 993 So.2d 1100 (Fla. 1st DCA 2008).

A. No, he does not.

Q. Okay. And is that opinion based on the fact that the heart catheterization was normal?

A. Yes.

Q. Is that based on anything else other than the heart cath, or primarily the heart cath?

A. No, that is the gold standard looking for atherosclerosis. The -- the cardiac catheterization is the gold standard test, and it did -- the cardiac cath revealed no evidence of coronary atherosclerosis.

Q. And then Doctor, I provided another case to you, it's the Bivens v. City of Lakeland case, and that case discusses disability. And in that case, what they talked about in terms of a disability, disability doesn't mean that you're taken off work for diagnostic testing or for an evaluation or determination as to a diagnosis. And so my question based on that -- your review of that Bivens case and the fact that the claimant never had any symptoms and was able to work full-time as a firefighter, except for the initial period after his accident when he saw a cardiologist and went to have a heart cath, would you agree that the claimant in this case does not have a disability? (E/C/SA-1. pp. 12-13).

.....

A. Now, according to the patient, Mr. Behrig, he -- he never had any symptoms of shortness of breath, swelling in the feet, or anything else that you would see with a cardiomyopathy. It was an incidental finding on a WIPE scan, and it was confirmed by the cardiologist Dr. Dor, by -- by his own echocardiogram, and then a cardiac cath was initiated. It was done as an outpatient, and to my knowledge, he was not even kept in the office. I mean, he was not kept in the hospital where he had the heart cath done. It was an outpatient.

On cross-examination, **Dr. Parikh acknowledged that cardiomyopathy is heart disease, in a very generic term, but it factors in**. As to whether cardiomyopathy is a structural or functional abnormality of the heart, Dr. Parikh explained "*That's a very -- a structural -- so very interesting question. It is a structural problem, okay? But not often does it have to be functional, okay? So the manifestation of a disease is different for all -- for all different patients, so good question. For Mr. Behrig, he had a structural issue where his heart was -- ejection fraction was weak, but functionally he had no manifestation of it, he had no limitations with it."* (E/C/SA-1, p. 16).

Dr. Parikh further clarified how the cardiology community defines heart disease: *"heart disease is a very generic term, so it's a catchall phrase, so it's really not used in -- in the cardiology world because* ***we should know better*** *because heart disease can be atherosclerosis, it can be a cardiomyopathy, it can be a valvular issue, it can be an arrhythmia, it can be a microvascular angina.. .. it's a very, very generic term that most cardiologists would shy away from using. I'll just speak for myself.* ***I would never use the term heart disease. …. it's non-committal and doesn't tell you anything. My patients that have heart disease know what type of heart disease they have, CAD which is coronary artery disease, atrial fibrillation which is an arrhythmia, valvular stenosis or cardiomyopathy.*** *They would have more specific terminologies."* (E/C/SA-1, p. 17). Emphasis added.

Dr. Parikh did not believe the claimant suffered an impairment of health as a result of the cardiomyopathy, as he was asymptomatic. The abnormality was an incidental finding. *"Screening ultrasounds, echos are done and it is very difficult for patients to think that their heart's safe when they're exercising and they're not having symptoms and they're pushing their hearts. And Mr. Behrig definitely pushed his heart, he was very active. So yeah, oftentimes patients don't know that they have a -- a weak heart."* He acknowledged that the claimant's ejection fraction was reduced called it "mild to moderate." The rate was 38% via Life Scan, and 40% during cardiac catheterization, measured 1 month apart. A normal ejection fraction rate is between 55% and 70%. (E/C/SA-1, pp. 18-19).

Dr. Parikh he went on to provide a very clear analogy to show how cardiomyopathy affects the heart's function. *"So cardiomyopathy, theoretically, okay, is basically – is when the heart weakens, all right? So ejection fraction is the strength of the heart. It's basically -- and I like to consider the heart to be like the engine of the of the body, okay? And the engine of the heart -- of the body has valves and it has electrical, it has plumbing, and then it has horsepower, okay?* ***So the ejection fraction is equivalent to the horsepower and the strength of the heart****. So if you had 100 cubic centimeters of blood every time the heart beat, it would eject a normal 55 to 70 cubic centimeters of blood, and then you would get an injection fraction of 55 to 70 percent, okay? So he was down to 40 percent ejection fraction and a cardiomyopathy. In the majority of cases, if you went from 200 horsepower to a let's say 125 horsepower, you would feel that in the get-up and go when you put the accelerator in. You may not feel it going, you know, 30, 40 miles an hour, but you'll definitely feel it 60, 70 miles an hour. But as I said previously, I have many patients that are having weak hearts, but are able to manifest 80 miles an hour. And -- and Mr. Behrig, according to what he said and the activity levels he did, he was acting and driving his heart like a person with a normal ejection fraction, normal horsepower.* ***He did not manifest. I think that's -- we don't know why that happens. I think it's has not been explained yet, but it's clearly seen numerous times in my practice and in my 25 years of treating patients.***
(E/C/SA-1, pp. 19-20). Emphasis added.

Dr. Parikh explained that the most common type of cardiomyopathy starts in the left ventricle of the heart. There are other types, such as weak heart cardiomyopathy, thick still heart cardiomyopathy, and even the word cardiomyopathy is being heard less and less. But the cardiomyopathy that Mr. Behrig had was in the left ventricle, the more common cause of cardiomyopathies; and the left ventricle is a part of the heart. (E/C/SA-1, p. 21). The left ventricle is the main pumping chamber of the heart, and it is where the right side of the heart collects the blood that has used up oxygen and nutrients, pushes it to the lungs, the lungs feed the blood in the hemoglobin with the oxygen and nutrients, and the left side of the heart, especially the left ventricle, pushes it out to the aorta and rest of the body, for survival. Cardiomyopathy IS weakened heart muscle. (E/C/SA-1, p. 23). It is a compromised functioning of the heart muscle. It can make the valves leaky, creating an increased risk for heart failure. (E/C/SA-1, pp. 22-23). Dr. Parikh went on to testify in detail how cardiomyopathy precisely leads to congestive heart failure. He pointed out that the claimant's testing in January 2025, had an ultrasound that showed trivial mitral regurgitation, and an enlarged left atrium. (E/C/SA-1, p. 26).

At the time of the IME examination with Dr. Parikh, the claimant's cardiomyopathy had resolved, his ejection fraction increased to 55%-60% I reevaluated him when he came in, and actually his cardiomyopathy had resolved, it got better, okay? His ejection fraction increased to 55 to 60 percent. The medication he had received had strengthened his heart, making things much better when seen in June. (E/C/SA-1, p. 30). **"It was reasonable for Dr. Dor to take him out of work… I can't argue with another cardiologist. He may have seen something that I didn't what wasn't conveyed to me at the time."** (E/C/SA-1, p. 31). Emphasis added.

Per Dr. Parikh, all the treatment by Dr. Dor was reasonable and medically necessary. For the future, since the medication helped his ejection fraction, Dr. Parikh testified that the medications of Entresto, metoprolol, and spironolactone, which are the standard of care for patients with cardiomyopathies, and will be lifelong.

Ultimate Findings, Analysis and Conclusions of Law

The Presumption – of causation. As specified by statute:

112.18 Firefighters and law enforcement or correctional officers; special provisions relative to disability.

(*1)(a) Any condition or impairment of health of any Florida state, municipal, county, port authority, special tax district, or fire control district firefighter or any law enforcement officer, correctional officer, or correctional probation officer as defined in s. 943.10(1), (2), or (3) caused by tuberculosis, heart disease, or hypertension resulting in total or partial disability or death shall be presumed to have been accidental and to have been suffered in the line of duty unless the contrary be shown by competent evidence. However, any such firefighter, law enforcement officer, correctional officer, or correctional probation officer must have successfully passed a physical examination upon entering into any such service as a firefighter, law enforcement officer, correctional officer, or correctional probation officer, which examination failed to reveal any evidence of any such condition.*

The claimant has the burden to meet all four prongs of this statute in order to E/C/SA to rebut, by competent substantial evidence, a non-work-related cause. The claimant is only pursuing benefits under §112.18, not a specific event such as occupational disease under §440.151. Where the E/C/SA in the pretrial asserted that the burden on the claimant is clear and convincing evidence, this was incorrect: the burden to rebut the presumption is on the E/C/SA, but only by competent substantial evidence.

I find both doctors to be well-qualified as experts in the field of cardiology, and have testified in workers' compensation cases before. I find that the claimant, Paul Behrig, entered the fire service in 2004, at which time he underwent a pre-employment physical examination which revealed no evidence of hypertension or heart disease. He was sworn into service and able to

perform his duties as a firefighter, without limitation.

I find that the claimant is a member of a protected class of first responders, who entered the fire service with no evidence of hypertension or heart disease.

I accept that on May 8, 2024, the claimant underwent his annual physical examination required by his employer. The examination noted during a general ultrasound of the claimant's heart that his ejection fraction was reduced. The ejection fraction measures the blood-pumping function of the heart. This abnormality in the evaluation led the technician to suspend the rest of the test, and the claimant was relieved of duty as a firefighter until the ejection fraction abnormality was investigated, and he was cleared to return to duty by an appropriate physician. The preliminary diagnosis on May 8, 2024, was cardiomyopathy.

I find that cardiomyopathy is an impairment of the heart as contemplated by §112.18, Florida Statutes, and thus a covered condition. As outlined in great detail above, both experts testified consistently in support of this:

a. For as long as they have been practicing, at least 25 years, cardiomyopathy has been recognized as a form of heart disease. It was a cause of death in the 1950s and 1960s.

b. It causes damage to the heart muscle, and cardiomyopathy is by definition damage to the heart muscle, cardio - heart, myo - muscle, pathy - disease. The most common forms of cardiomyopathy start in the left ventricle, which as Dr. Parikh explained, serves a critical function in getting the oxygen and nutrients in the blood from the heart to the lungs and around the body.

c. Cardiomyopathy can manifest itself in a low ejection fraction, and can cause or create an increased risk for heart failure. If the heart's pumping function is allowed to remain impaired, blood can back up, valves can leak, and this can lead to congestive heart failure, which over time can be fatal.

d. I accept the testimony of both doctors that the medications were prescribed for the cardiomyopathy, and have been effective in improving the claimant's condition. I further accept that he will have to be on them for the rest of his life.

e. The treatment provided by Dr. Dor to the claimant in confirming the diagnosis, ruling out other conditions, prescribing medications and then allowing the claimant time on the medications, to see how they worked, before repeating the echocardiogram, was reasonable and medically necessary.

f. It is not unusual for a patient to feel asymptomatic when diagnosed.

g. I accept that both experts agreed that the claimant had heart disease, even when provided the holding in *Harlem*. While Dr. Parikh acknowledged that under the

definition in that case, the claimant would not have "heart disease" because there was no atherosclerosis, I found no indication in the doctor's deposition that he **agreed** with that definition; nor was he asked. When the doctor went on to state there was no heart disease because the catheterization was clean, the doctor was referring to atherosclerosis only.

I find that following the suspended annual evaluation, the claimant was seen and examined by his cardiologist, Dr. Isaac Dor, who performed an echocardiogram, and confirmed the abnormality noted by the technician with respect to the ejection fraction, and diagnosed cardiomyopathy. Dr. Dor ordered further testing to ensure that there were no underlying conditions causing the cardiomyopathy that required treatment, namely genetic testing and cardiac catheterization. These were negative, supporting there was no underlying genetic mutation, and no atherosclerosis. I agree with Dr. Borzak that the "clean" cardiac catheterization confirmed the diagnosis of cardiomyopathy.

On the matter of disability/incapacity, I reject the arguments of E/C/SA that because the claimant "felt fine", returned to full duty work, as well as pickleball after his six-week leave, he was not incapacitated. Further, I reject that the leave was solely for diagnostic purposes. I find neither doctor supported that. In fact, both doctors testified that only in retrospect could one consider how the claimant felt in hypothesizing that he could have worked during the period of May 8, 2024, to June 21, 2024.

The testimony of Dr. Parikh that because the cardiac catheterization was done as an outpatient, this supports no disability, is rejected. To the extent he disagreed with Dr. Borzak on that one question, I accept the opinion of Dr. Borzak as more in keeping with logic, reason, and the medical science as explained.

Further, the doctors agreed that the medications had to be started, titrated, and evaluated as well, in support of the period of time off of work. E/C/SA rely on *Bivens* to argue against a finding of incapacity, arguing that the cardiac catheterization, echocardiogram, and follow up with a cardiologist are nothing more than "diagnostics", rather than treatment for any covered condition. I disagree.

The First District Court of Appeal has addressed this issue many times. One of the best reviews of the "disablement – 4th prong" lines of cases is *Rocha v. City of Tampa*, 100 So. 3d 138 (Fla. 1st DCA 2012). Rocha was a firefighter who was undergoing a cardiac Stress Test during his annual physical. The exam showed abnormalities and the firefighter was immediately determined prohibited from firefighting. He was placed on restrictions, medicated and kept off of work until further assessment of his hypertension. An EMA had been assigned to address conflicts, including the restrictions, which the EMA physician thought were reasonable. (The matter was reversed primarily for the misapplication by the Court of the EMA testimony.)

The Court in *Rocha* cites the various statutory definitions of disablement, then addresses

how the definitions have been "elaborated" by case law, and the order of opinions that put the issue of disability in their appellate line of sight. In a case of first impression, the Court found that there is a situation between *Bivens/Shacklett*[7] (no medical work restrictions) and *Carney/McArtor*[8] (hospitalized for treatment so clearly incapable of working). Firefighter Rocha therefore met disability because his work restrictions were (a) legitimately imposed as medically necessary "because of the injury"; AND (b) created actual incapacity by interfering with his ability to "earn in the same or any other employment the wages which the employee was receiving at the time of the injury." Firefighter Rocha, like Lt. Behrig here, was instructed to stay away from fires.

I find the claimant has proven the fourth prong of the presumption, incapacity as a result of treatment for the covered condition.

Based on the foregoing, I conclude that the claimant, Paul Behrig, is entitled to the presumption of causation in §112.18, Florida Statutes.

Rebuttal of the Presumption – Reverse Presumption

The E/C/SA raised as an affirmative defense that "*If the court finds that the presumption requirements have been met, then there is competent, substantial evidence to rebut the presumption.*

There was no specific basis asserted for the rebuttal. The statute referencing rebuttal is §112.18(1)(c)1., which states:

> *For any workers' compensation claim filed under this section and chapter 440 occurring on or after July 1, 2010,* ***a law enforcement officer, correctional officer, or correctional probation officer*** *as defined in s. 943.10(1), (2), or (3) suffering from tuberculosis, heart disease, or hypertension is* ***presumed not to have incurred such disease in the line of duty as provided in this section if the law enforcement officer, correctional officer, or correctional probation officer:***
>
> > *a.* ***Departed in a material fashion from the prescribed course of treatment of his or her personal physician and the departure is demonstrated to have resulted in a significant aggravation*** *of the tuberculosis, heart disease, or hypertension resulting in disability or increasing the disability or need for medical treatment.*

This affirmative defense is not available to the E/C/SA, as reverse presumption/rebuttal, only applies to claims filed by law enforcement officers. Paul Behrig is a firefighter. However, even if this were available, I find no competent, substantial evidence has been presented to rebut the presumption of causation.

WHEREFORE, it is CONSIDERED, ORDERED, and ADJUDGED as follows:

[7] *Jacksonville Sheriff's Office v. Shacklett*, 15 So. 3d 859 (Fla. 1st DCA 2009).
[8] *Carney v. Sarasota County Sheriff's Office*, 26 So. 3d 683 (Fla. 1st DCA 2009); *City of Mary Ester v. McArtor*, 902 So. 2d 942 (Fla. 1st DCA 2005).

1. The claim for temporary total disability benefits from May 8, 2024, through June 21, 2024, is **granted,** at the maximum compensation rate. Payment shall be issued to claimant's counsel within 14 days of this Order.
2. The claim for interest and penalties on the above temporary total disability benefits is **granted**. Payment shall be issued to claimant's counsel within 14 days of this Order.
3. The claim for authorization and provision including scheduling, of an appointment with a cardiologist to treat the claimant's cardiomyopathy is **granted**. An appointment letter shall be issued to the claimant with a copy to counsel, within 7 days of this Order, with the appointment to take place within 30 days of this Order.
4. The claim for attorney's fees and costs to be paid by the E/C/SA for the benefits secured herein, is **granted**. Jurisdiction is reserved as to quantum, if necessary.
5. The petition for benefits of January 21, 2025, is **dismissed with prejudice.**

DONE AND SERVED this 19th day of August, 2025, in Altamonte Springs, Seminole County, Florida.

Jill E. Jacobs
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APPENDIX I TO FINAL COMPENSATION ORDER
CLAIMS AND DEFENSES

Claims:

1. Temporary Partial Disability: payment of temporary partial disability benefits starting from 5/8/2024 to present and continuing at the correct rate. (*withdrawn).*
2. Temporary Total Disability: payment of temporary total disability benefits starting from 5/8/2024 to present *and continuing* at the correct rate. (*amended to June 21, 2024).*
3. Authorization, payment and scheduling of medical care and treatment with a cardiologist or appropriate physician to treat claimant's disabling arterial and cardiovascular hypertension and/or heart disease.
4. Attorney fees and/or costs: attorney fees pursuant to section 440.34, Florida Statutes or as otherwise provided by law. Reasonable costs pursuant to section 440.34, Florida Statutes, or as otherwise provided by law.
5. Penalties and/or interest: penalties and interests pursuant to section 440.20 (6)-(8), Florida Statutes, or as otherwise provided by law.
6. Compensability: compensability of disabling arterial and cardiovascular hypertension ***and/or*** heart disease.

Defenses:

1. The entire claim has been denied as there is no clear and convincing evidence of an accident, injury, or illness occurred arising out of the course and scope of employment.
2. The claimant's condition does not meet the definition of heart disease per *North Collier Fire Control and Rescue District/PGCS v. Harlem.*
3. The claimant does not meet the criteria for a disabling event or disability because he only underwent diagnostic testing. The claimant is working full time and is not disabled.
4. The claimant does not meet the F.S. 112.18 presumption requirements for hypertension or heart disease. *If the court finds that the presumption requirements have been met, then there is competent, substantial evidence to rebut the presumption.*
5. The claimant's wage loss is unrelated to a work-related accident or injury. The claimant is working full time for the employer, so no TTD is due.
6. No PICA due or owing.

Claimant's Objections and Avoidances:

1. As to the first listed defense, this is an incorrect standard [of proof].
2. Waiver: As to cardiomyopathy not qualifying as heart disease, there is no medical evidence to support this; cardiomyopathy has long been held to be heart disease.
3. Objection as to disability defense and that his absence from work was solely for diagnostic testing: the claimant was restricted from working due to extremely low ejection fraction, not diagnostic testing.
4. As to not qualifying for presumption and rebutting the presumption, Claimant asserts lack of specificity.
5. There is no evidence to support defense that *"the Claimant is working full time for the employer, so no TTD is due."*

APPENDIX II TO FINAL COMPENSATION ORDER
DOCUMENTARY EXHIBITS

Judge's Exhibits (JCC-#):

1. Composite Petition for Benefits filed January 27, 2025, attachment, and response (Dockets #10, #11, and #12).
2. Mediation Conference Report (Docket #23).
3. Pretrial Stipulation filed June 18, 2025 (Docket #24).
4. The Claimant's trial memorandum, for argument only (Docket #38).
5. Composite: E/C/SA's trial memorandum, with attached cases, for argument only (Dockets #40 and #42).
6. Order Granting Motion for Claimant to Appear by Zoom entered July 17, 2025 (Docket #41).

Claimant's Exhibits (C-#):

1. Pre-employment physical, 2004 (Docket #25).
2. Payroll records from date of accident through return to work (Docket #26).
3. Wage statement (Docket #27).
4. Deposition of Claimant's IME, Steven Borzak, M.D., taken June 11, 2025 (Docket #28).
5. Exhibit 1 to Dr. Borzak's deposition, his CV (Docket #29).
6. Exhibit 2 to Dr. Borzak's deposition, in 5 parts (Dockets #30 through #35). E/C/SA objected to all parts, based on hearsay and authenticity, as they are records from personal providers, not authorized. The claimant responded that these records were provided to both Dr. Borzak, and to Dr. Parikh, E/C/SA's IME, for review[9]. I find the records are admissible only to show what data both experts relied on, for purposes of their reports and/or testimony in this matter. *Objection overruled.*
7. Exhibit 3 to Dr. Borzak's deposition, his IME report dated January 20, 2025 (Docket #35).

E/C/SA's Exhibits (E/C/SA-#):

1. Deposition transcript of IME, Amish Parikh, M.D., taken June 25, 2025 (Docket #37).

[9] This is evident in the deposition transcripts of both experts.