IN THE SUPREME COURT OF FLORIDA

CASE NO: 95,515
Third DCA Case No: 98-2575

FARREN IVEY,

Petitioner,

-vs.-

ALLSTATE INSURANCE COMPANY,
Respondent

ON PETITION FOR DISCRETIONARY REVIEW
FROM THE DISTRICT COURT OF APPEAL,
THIRD DISTRICT OF FLORIDA

AMICUS CURIAE BRIEF OF THE
ACADEMY OF FLORIDA TRIAL LAWYERS

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The Amicus Curiae, Academy of Florida Trial Lawyers, hereby certifies that the type used in this brief is Arial 14 point.

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STATEMENT OF THE CASE AND FACTS

At a non-jury trial on the issue of entitlement to attorney's fees under section 627.428, Florida Statutes, the trial court made findings of fact which were inconsistent with the record evidence and findings which were irrelevant to the issue of entitlement. After so doing, the trial court denied plaintiff's entitlement to attorney's fees. On appeal, the Circuit Court, Appellate Division of the 11th Circuit, Miami-Dade County, Florida, reversed citing portions of the record which clearly demonstrated that Allstate failed to conduct any reasonable investigation within the statutorily required period of thirty days from the time it received notice of a claim for benefits. [1]

[1] Page 2 (R-36) of the opinion states "Allstate apparently only reviewed the bill and not the physician's report, and

By petition for writ of common law certiorari, the Third District reversed making its own factual determination that Allstate's conduct was not "wrongful" and reversed the Circuit Appellate division. (R-191-195). This petition to the Florida Supreme Court Followed. [2]

The essential facts of the case are that plaintiff Ivey was injured in an automobile accident for which she was covered for PIP coverage with Allstate. She made a claim for benefits by submitting the required no fault application and signed a medical authorization form required by Allstate to permit it to request medical records as part of its investigation. Despite having been given the right to obtain medical records from her treating

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therefore, mistakeningly [sic] assumed that the doctor's bill was for one modality rather than two, and that the charge was in excess of what was normally charged for one modality"...Page 3: "It was not until November 1995, nine months after the original claim was filed that Allstate discovered its mistake during the deposition of the doctor" [emphasis added]...Page 3: "Allstate did not review the other documents submitted, nor did they contact the doctor regarding an explanation of his charge(s)" (R-37). [emphasis added].

[2] Ivey has disputed that the decision of Circuit Appellate division was subject to review by the Third District Court of Appeal based on the "simple error" standard of review and obtained conflict review based on decisions from other districts holding that an erroneous interpretation of law is insufficient to grant certiorari review. See Petitioner's Jurisdictional Brief, Page 8.

physician, Allstate declined to do so. [3]

As part of the claim for benefits, Ivey's treating physician Theodore Struhl, M.D. submitted a claim form known as a HICFA form along with his medical records which included his medical report of the examination and treatment of Ivey. The HICFA form clearly indicated treatment to two different body parts for each of the visits for which therapy was administered. Dr. Struhl's medical report clearly indicated physical therapy was being administered to two different body parts on each therapy date.

Upon receipt of Dr. Struhl's bill, rather than conducting an investigation which would have included reading of Dr. Struhl's report and careful review of the HICFA form, Allstate submitted the bill to the outside medical review service which concluded that Struhl was charging $55.00 for one physical therapy treatment. In fact, Dr. Struhl's charges were $27.00 per treatment a fact Allstate could easily determine with a single tepehone call.

Allstate, relying on the service it hired, paid $36.00 which is the amount it was told was reasonable for one treatment. Because Allstate

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[3] Allstate also failed to review Dr. Struhl's medical report which clearly indicated two treatments to two separate body parts. (R-37-38). Instead, it sent the bill to an outside review service and relied solely on its evaluation.

failed to pay the statutorily required 80% of the medical bills submitted, Ivey retained an attorney who brought an action against Allstate for breach of contract.

In her complaint, Ivey sought attorney's fees pursuant to Section 627.428, Florida Statutes. Despite having at least 20 days after service of the complaint to review the matter and decide to settle, Allstate chose to defend the action, answered the complaint and raised affirmative defenses including a challenge to the necessity and reasonableness of the charges claimed.

In defense of the action, Allstate initiated discovery which included the deposition of the treating physician, Theodore Struhl, M.D some nine month's after the claim was submitted to it. During Dr. Struhl's deposition he pointed out to Allstate's attorney what a reasonable and simple investigation by a claims adjuster would have revealed, i.e. that the HICFA form referenced two different body parts and that the medical report of plaintiff's examination and treatment in Allstate's possession prior to institution of the action clearly mentioned physical therapy to both injured body parts.

Upon learning that it underpaid the claim, Allstate, within thirty days, paid the difference in the amounts that it owed. Thereafter, plaintiff's counsel moved for attorney fees and the trial court held a fee entitlement hearing and entered the order from which appeal was taken.

At the fee entitlement hearing, Allstate's attorney took the position that Allstate paid the benefits within 30 days of Dr. Struhl's deposition, a fact relied on by the trial court as determinative of the entitlement issue. [4]

On appeal, the Circuit Appellate Division pointed out that Allstate's conduct was wrongful because it failed to conduct any reasonable investigation and the information in its possession prior to institution of the action would have shown there were two physical therapy treatments per session, or at the very least, would have put it on notice to make further inquiry and investigation.

Because Allstate failed to do so, the Circuit Appellate Division reversed and remanded finding entitlement to fees. On certiorari review, the Third District ignored critical facts in the record and relied solely on what it considered to be an "error" in the doctor's bill.

The Third District failed to recognize that the duty to investigate is an affirmative duty placed on the no fault carrier and not on the claimant or provider and ignored well settled law that payment after institution of an action under the PIP statute entitles a claimant to fees. The petition for review by the Florida Supreme Court timely followed.

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[4] At the hearing, Allstate's lawyer charged that "Allstate received that initial bill from Dr. Struhl under, again, false pretense that it was one unit of electrical stimulation" (T-25)

SUMMARY OF THE ARGUMENT

Payment of benefits by a no fault insurer after suit is initiated entitled the plaintiff to reasonable attorney fees as a matter of law. Allstate's failure ot conduct an adequate investigation until after suit was brought against it constitutes a wrongful withholding of benefits. There is no statutory exception to a PIP insurer's liability for fees.

ARGUMENT

The decision of the Third District should be reversed because under Ivey, an insurer can fail to adequately investigate, ignore contradictory claim facts, mistakenly reduce bills which are due and payable and fail to pay compensable bills timely, all with impunity rather than the penalty required to be imposed against it by Sections 627.736(8) and 627.428, Florida Statutes.

Unless Ivey is reversed, insurers will fail to investigate claims and risk litigation knowing they can then conduct their investigation after suit is filed by a plaintiff and then "discover" their obligation and pay within thirty days and will have a chilling effect on attorneys who ordinarily would accept representation of personal injury protection claims because they would be unwilling to risk non-payment.

Insurers will have no reason not to deny benefits otherwise due resulting in more litigation contrary to the intent of the legislature in enacting the no fault law as a means of decreasing litigation.

The Ivey decision improperly changes Florida law by permitting an insurer to fail to adequately investigate a claim within thirty days, wait until it is sued, then initiate an investigation and escape liability for fees by the simple expedient of conducting litigation discovery and becoming "enlightened" as to its contrctual and statutory obligation to pay.

If approved, Ivey would result in more claim denials and more litigation because insurers would be able to drag claimants through the court system with the knowledge that insurers have a "fighting chance" to escape statutory liability for fees. Such a practice would be directly contrary to the spirit of the no fault law and the intent of the legislature to reduce or avoid litigation.

The entire premise of the District Court opinion is that "Allstate did not pay the entire claim due to an error in the doctor's bill" and that there is a "level of 'wrongful' conduct" which entitles a claimant to an award of attorney's fees but is incorrect. The alleged doctor's bill "error" is obvious from a simple review of the other materials submitted to make the claim.

Dr. Struhl's medical report clearly indicates two treatments on each day to two different body parts. [5]

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[5] In this regard, The Academy does not concede that the HICFA form contained an "error" since it clearly reflected two different body parts. Rather, it is The Academy's position that at most, the HICFA form constituted an ambiguity which gave rise to a duty to make further inquiry by the insurer. Further, it is not conceded that it is the HICFA form which controls the obligation to pay since all insurers require submission of complete medical records as part of the claim materials and the proof of claim required by the PIP statute is the application for no fault benefits. Allstate now seeks to benefit from its own failure to conduct adequate investigation and its decision to ignore materials which it itself requires to be submitted to entertain the medical claim. An insurer should not be able to

As between the insurer who has the right and obligation to investigate, and the claimant who is deprived of the full payment required by statute and insurance contract, it is the public policy of the State of Florida to interpret the no fault law liberally in favor of the insured. The District Court opinion turns the public policy of Florida on its head.

It has long been the law that a no fault insurer has thirty days from receipt of proof of claim to investigate, verify the claim and make the appropriate payment. See Dunmore v. Interstate Fire Ins. Co., 301 So.2d 502 (Fla. 1st DCA 1974). In Dunmore, the First District held "the insurance company has thirty days in which to verify the claim after receipt of an application for benefits.

There is no provision in the statute to toll this time limitation. The burden is clearly upon the insurer to authenticate the claim within the statutory period. To rule otherwise would render the recently enacted 'no fault' insurance statute a 'no-pay' plan-a result we are sure was not intended by the legislature". Id.

In 1996 the Fourth District followed Dunmore in the case of Martinez v. Fortune Insurance Company, 684 So.2d 201 (Fla. 4th DCA 1996). In holding the insurer is obligated to pay based on receipt of "written notice" of a loss rather than "proof" of a loss, the Fourth District held the insurer liable

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escape liability for attorney's fees by the simple expedient of waiting until litigation to conduct adequate investigation.

for fees for failure to pay within the statutorily required time period even though the carrier defended on the theory that it sent a disability evaluation request to the claimant's physician who did not respond to the request.

In Martinez the carrier at least made an effort to investigate by contacting the treating physician, something that Allstate failed to do here. Dunmore has also been followed by the Third District in Fortune Insurance Company v. Pacheco, 695 So.2d 22 (Fla. 3d DCA 1997) [insured cannot be required to submit all supporting medical records before 30-day period for payment begins to run].

In Pacheco, the insurer attempted to toll the thirty day time period to evaluate and pay by requesting additional information. The Third District held "The burden is clearly upon the insurer to authenticate the claim within the statutory period" citing the "no-pay" language of Dunmore. [6]

In Crooks v. State Farm Mutual Automobile Insurance Company, 659 So.2d 1266 (Fla. 3d DCA 1995), the Third District found entitlement to

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[6] As previously mentioned, during the entitlement hearing, Allstate's attorney made the accusation that "Dr. Struhl under, again, the *false pretense* that it was one unit of electrical stimulation. They paid what was the reasonable and customary charge for that one unit".[emphasis added]. In Martinez, the Third District recognized that "If fraud is suspect, then the company or the Division of Insurance Fraud should investigate". There is no evidence in the record that either Allstate or the Division of Insurance Fraud investigated a fraudulent claim in this case.

attorney fees where the insurer failed to pay within 30 days after written notice without reasonable proof of nonresponsibility. In Crooks, State Farm failed to pay within the statutory period because the bills were not submitted on a particular "in-house" claims form.

Crooks is factually analogous because the trial court excused State Farm's failure to pay because the violation was merely "technical". In reversing the trial court, the Third District held "By making this ruling, the trial court, in effect, attempted to create an exception to Section 627.736(4)(b) which does not exist.

Allstate's argument at the entitlement hearing that no fees are due because payment was made voluntarily rather than by settlement should be rejected. Although it is clear a settlement is the "functional equivalent" of judgment (Wollard v. Lloyd's And Companies of Lloyd's, 439 So.2d 217 (Fla.1983) and its progeny), entitlement to fees is not dependent on "settlement" and many cases have held that payment after institution of the action is sufficient to entitle a claimant's attorney to fees pursuant to Section 627.428 as has been held even prior to Wollard. See Gibson v. Walker, 380 So.2d 531 (Fla. 5th DCA 1980), [statute imposing obligation for fees cannot be avoided simply by paying proceeds after suit is filed but before judgment is actually entered]; Augustin v. Health Options Of South Florida, Inc., 580 So.2d 314 (Fla. 3d DCA 1991), [change of position after

suit filed and making of payment moots the action and is the functional equivalent of a judgment or verdict in favor of plaintiff entitling plaintiff to award of attorney's fees]; Castillo v. Tracor Marine, Inc., 474 So.2d 322 (Fla. 3d DCA 1985), [payment after lawsuit filed prior to judgment entitles plaintiff to attorney's fees pursuant to Section 627.428].

The real issue as to entitlement in this action is whether plaintiff was compelled to institute action in order to obtain payment of the benefits sought. The uncontradicted evidence in this case is that Allstate made payment only after plaintiff was compelled to retain her attorney to institute an action against Allstate. When sued, Allstate had no intention to pay as evidenced by its answer and affirmative defenses.

Only after the action was well under way did Allstate conduct the reasonable investigation which it could and should have conducted during the pendency of the claim and discovered that additional benefits were due. The suit and attorney services were necessary to obtain performance of the insurance contract. It cannot be said the efforts of Ivey's attorney were unnecessary since Allstate's inaction (failure to properly investigate) caused plaintiff to resort to litigation to compel the payment ultimately made by Allstate.

The value of the attorney's services is evidenced by Allstate's

"enlightenment" during discovery which caused it to change its litigation position and agree with plaintiff's claim and pay the benefits due. As a matter of law, plaintiff's counsel is entitled to fees pursuant to Sections 627.736(8) and 627.428, Florida Statutes.

CONCLUSION

Because Allstate's failure to properly investigate caused plaintiff to retain counsel and resort to litigation in order to obtain the benefits due, the trial court's denial of plaintiff's claim to entitlement to fees was properly reversed by the Circuit Appellate Division and should not have been disturbed by the Third District. The Supreme Court should vacate the decision of the Third District and remand to the trial court to award reasonable attorney's fees pursuant to Section 627.736(8) and 627.428, Florida Statutes.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing brief was served by U.S. Mail on October 12, 1999 to : Roy D. Wasson, Esq., counsel for petitioner, 450 Gables One Tower, 1320 South Dixie Highway, Miami, Florida 33146; Ross B. Gampel, Esq., counsel for plaintiff, Kelmick & Gampel, P.A., 1953 S.W. 27th Avenue, Miami, Florida 33145; Frank S. Golstein, Esq., counsel for Allstate, Green, Murphy, Wilke & Murphy, P.A., Suite 200, 633 South Andrews Avenue, Fort Lauderdale, Florida 33301; and Richard A. Sherman, Esq., counsel for Allstate, 1777 South Andrews Avenue, Suite 302, Fort Lauderdale, Florida 33316.

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