IN THE SUPREME COURT OF FLORIDA

CASE NO. 95,515

Florida Bar No. 184170

FARREN IVEY,

Petitioner,

vs.

ALLSTATE INSURANCE COMPANY,

Respondent.

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

BRIEF OF RESPONDENT ON THE MERITS
ALLSTATE INSURANCE COMPANY

(With Appendix)

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POINTS ON APPEAL

I. THE THIRD DISTRICT APPLIED THE CORRECT LEGAL STANDARDS IN REINSTATING THE TRIAL JUDGE'S ORDER AFTER A NON-JURY TRIAL, THAT PAYMENT WAS TIMELY MADE AFTER ALLSTATE RECEIVED NOTICE OF THE CLAIM AND THE DECISION IN IVEY MUST BE AFFIRMED.

II. THE TRIAL COURT EXPRESSLY FOUND THERE WAS NO CONFESSION OF JUDGMENT; THE THIRD DISTRICT APPROVED THIS RULING; THE PLAINTIFF HAS GIVEN THIS COURT NO REASON TO REVERSE AND THE DECISION IN IVEY MUST BE AFFIRMED; AS IT IS NOT IN DIRECT AND EXPRESS CONFLICT WITH FLORIDA LAW.

III. THERE IS NO CONFLICT WITH THE STANDARD OF REVIEW FOR CERTIORARI CASES; THEREFORE THERE IS NOTHING FOR THIS COURT TO RESOLVE; AND THE DECISION IN IVEY MUST BE AFFIRMED.

CERTIFICATION OF TYPE

It is hereby certified that the size and type used in this Brief is 12 point Courier, a font that is not proportionately spaced.

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Health Insurance Claim Form (HICF) dated March 16, 1995 . . . . A4

Health Insurance Claim Form (HICF) dated March 16, 1995 . . . . A5.

STATEMENT OF THE FACTS AND CASE

After a non-jury trial, the judge found that the Plaintiff's claim for PIP benefits was timely paid within 30 days; and payment was not a confession of judgment, entitling the Plaintiff to attorney's fees and costs. The gist of the Plaintiff's appeal is that the judge's fact finding was wrong; the circuit court's substituted fact finding was right; so the Third District used the wrong legal standard to reinstate the judge's decision. However, the real complaint by the Plaintiff is that she did not receive attorneys' fees and costs, when Allstate paid the $106.40 claim that was discovered during litigation. Attached to this Brief are the records relied on by the trial judge and the Third District to find a timely PIP payment within 30 days (A 3; 4-5). It was the circuit appellate court that used the wrong standard of review from the non-jury trial; and it erroneously shifted the burden of proof to the insurance carrier. Allstate Insurance Co. v. Ivey, 728 So. 2d 282 (Fla. 3d DCA 1999)(A 1-2) is in line with Florida law; it was based on the right standards and case law; and must be affirmed. The Plaintiff gratuitously claims, as does the Amicus that not paying attorneys' fees is a violation of Florida law, public policy, due process; and now no PIP claimant will ever be able to hire a lawyer again. Ivey, is a fact limited case, with no new standards, law, nor sweeping changes. Mrs. Ivey was never billed nor paid the $106.40; and her attempt to create a basis for fees was properly rejected by the judge and the Third District.

On December 13, 1994, the Plaintiff, a pedestrian,

apparently was walking on a sidewalk when she stepped off the sidewalk and a car driven by Mr. Arias struck her in the lower left leg and right shoulder, because she had fallen on a man's bicycle, which was standing near her (R 1-3). Dr. Struhl, a surgeon/gynecologist, treated Ms. Ivey and her physical therapy included unattended electrical stimulation therapy (CPT Code 97014) between December 16, 1994 and January 10, 1995 (D 10; (A 3-5).

The bill for Dr. Struhl's services was $710; the Plaintiff made a PIP claim to Allstate in February and attached an "attending physicians report" (A 3) and in March, 1995 the Health Insurance Claim Form (HICF) for payment of this amount was submitted to Allstate (D 11; T 5-6; A 4-5). In April, 1995 Dr. Struhl received a reduced 80% PIP payment from Allstate in the amount of $461.60 accompanied by an explanation of benefits ("EOB") form from Allstate, explaining how it arrived at the payment of this amount for his bill (D 16-18). Allstate determined that the reasonable and customary charge for a single unit of electrical stimulation therapy was $36. The amount charged for one unit as billed by Dr. Struhl was $55. The billed units were reduced by $19 each (R 315; 353). Dr. Struhl was aware that he had received a reduced amount for his bill; deposited the check and did nothing about the difference (D 17; 20).

The following month, the Plaintiff sued Allstate for medical expenses and routine personal injury damages (R 1-3). Allstate filed a Request for Admission, for the Plaintiff to admit that

the only bill at issue was the reduction of Dr. Struhl's bill for the physical therapy treatments between December 16, 1994 and February 1, 1995 (R 5-7). In September, 1995 the Plaintiff noticed the case for trial (R 31). Eventually, the Plaintiff admitted that the only bill at issue was the reduction of Struhl's total bill of $710; and the Plaintiff denied that the bill had been timely paid (R 155-156).

On November 14, 1995, Dr. Struhl's deposition was taken to ascertain how he computed his charges for the electrical stimulation therapies at issue (D 1-9). Although Dr. Struhl initially stated that he charged $55 per one unit of electrical stimulation, that turned out not to be the case at all (D 13). For the first time anywhere, it came to light that according to Dr. Struhl, the $55 was for two treatments or units, not one (D 22).

Dr. Struhl admitted that he did not and had not considered any collection action against Ms. Ivey (D 22-26). Dr. Struhl never notified Ms. Ivey or her attorney that he was planning to collect any monies not paid by Allstate (D 24-26). Dr. Struhl admitted he did not provide Ms. Ivey with a fee schedule or price list outlining how many units of electrical stimulation were being performed, per visit, or the charges for that treatment (D 29).

For the first time in over one year, since the electrical stimulations were performed and billed, Allstate learned at the doctor's deposition that the $55 charge for CPT 97014 was for two units of electrical stimulation, not one, as indicated on the

report and HICF form (D 31; A 3-5). Dr. Struhl said that he charges $35 per unit of electrical stimulation, and gives his patients a break for multiple units; again something not reflected in the Records (D 32-33; A 3-5). He did not know if his billing staff had broken that charge up anywhere, but that the $55 was for two units, not one; so there was a total of 4 treatments on 7 days, not 7 as reflected in the documents (D 32).

After reviewing a copy of his bill sent to Allstate, Dr. Struhl recognized that his bill did not indicate at all that each $55 charge was for two units of electrical stimulation (D 32). Dr. Struhl again admitted that the bill sent to Allstate by his office was devoid of any references that the $55 charge was for two units of electrical stimulation (D 33). Dr. Struhl then said that "perhaps what we should have done is put it for two units each time" (D 33). The papers showed "1" written in for number of units (A 3-5).

Ida Hernandez, who works for Dr. Struhl, said that Dr. Struhl never indicated on his records how many units of electrical stimulation were performed (D 34). In fact, one of the reasons for the non-delineation of units was because they do not have enough space on the chart to designate them (D 34). Dr. Struhl's record simply indicated the diagnosis, but did not indicate what "area(s) is/are" receiving the electrical stimulation (D 34).

Dr. Struhl related that he forwarded Allstate a Health Insurance Claim Form ("HICF Form") regarding his billing of the electrical stimulation (D 36; A 4-5). He explained that the

procedure code billed was CPT 97014 and in the box labeled "charge," the HICF form denoted $55 (D 37; A 4-5). Dr. Struhl conceded that the billing on the HICF form was incorrect (D 37, 46; A 4-5).

Dr. Struhl then exclaimed, "[w]e're going to send you a new bill and it's going to be delineated very well and the price is going to be delineated..." and "[w]ell, these amounts [referencing his billing forms and HICF form] are wrong" and Allstate was going to get another bill (D 39). In other words, for the first time, on November 14, 1995, a claim was being made for 7 additional units of therapy, than what was originally requested, at a rate of $27.50 each; far less than the $36/unit Allstate had already paid per unit as reasonable (D 39).

The following is the testimony of Dr. Struhl in November 1995, that formed the basis for the trial court's ultimate ruling in the non-jury trial in this case:

> [Mr. Goldstein]
> Q. And what would you charge them for an unattended electrical stimulation?
>
> * * *
>
> [Dr. Struhl:]
> A. Same thing.
>
> Q. The $55?
>
> A. 55 is for two. 35 is for one.
>
> Q. Because all I have here, Doctor, if I can reference you back to that, and if you want to reference your specific bill for this, please correct me if I'm wrong, I have here that the $55 was for one unit.
>
> A. No, for two. I don't know if they broke it up anywhere, but it's for two units, for two treatments, two physical therapy

treatments, which we charge $35, but if we have two, we only charge 55.

Q. Okay. Because I'm referencing your bill which is labeled Exhibit 1 and that indicates that there were five.

(A 3).

A. Five times 55.

Q. Right, which would be -- Which would mean that it was $55 per unit, per --

* * *

Q. (By Mr. Goldstein) Can you reference on there, in your file there, where it references that the $55 is for two electrical stimulations?

A. Does it say it here?

Q. I'm just trying to find out where it is, because I --

A. <u>It doesn't say it on the bill</u>, but that's what it is, because here, in the regular report, see, physiotherapy, three time a week, two-one, lateral aspect of the left lower leg, and two to the right shoulder. That means there's two different modalities.

Q. <u>Does it reference that it's for two different modalities anywhere in your bill that you sent to Allstate</u>?

A. <u>In the bill it doesn't, but that's what it is</u>.

Q. Because what our understanding is, if you look at the bill that was forwarded to Allstate, it doesn't indicate whether or not it was for one or two units.

A. <u>The bill does not. I agree with you</u>.

Q. So would --

A. But it is for two. And perhaps what we should have done is put it for two units each time. $55, however, is for two units. We only charge $35 for one unit.

(Discussion off the record.)

THE WITNESS: Ida, he's asking me this question. We know we charge him for two units each time, but he says where on the bill does it say he got charged for two units each time. All it says here is the five times 55.

IDA HERNANDEZ: Marie's the one that posts that.

THE WITNESS: Do we ever put down how many units?

IDA HERNANDEZ: No. We always put it like that, the dates. We go by the chart, whatever you put.

THE WITNESS: $35 for one place? $35 for one place and $55 if it's two different places?

IDA HERNANDEZ: Um-hmm.

THE WITNESS: So we give them off a few dollars.

IDA HERNANDEZ: Um-hmm.

THE WITNESS: Instead of 70, it's 55.

IDA HERNANDEZ: 55.

THE WITNESS: <u>But it doesn't actually say it right here that it's two units</u>.

IDA HERNANDEZ: <u>No</u>. It will -- <u>It doesn't say it here</u>. In the chart, yes, but in this, no, because we don't have too much space to put it on.

(D 31-34).

* * *

MR. GOLDSTEIN: Back on the record.

Q. (By Mr. Goldstein) Doctor, I'm showing you what's been marked as Defendant's Exhibit Composite 2, which is a copy of the health insurance claim form?

(A 4-5).

A. Correct.

Q. And this is the claim form that you would have submitted to Allstate for billing?

A. Correct.

Q. And if you could reference that, this claim form which is marked Exhibit 2 --

(D 36).

* * *

Q. (By Mr. Goldstein) Next to the fifty-five-dollar amount --

A. Okay.

Q. -- where it says if days or units -- Do you see that little box there?

A. Yes.

Q. Okay. What does it say next to that?

A. One.

(A 3).

* * *

Q. Okay. But what I'm asking you is, where on the bill does it delineate that this $55 was for two units of treatment?

A. Nowhere. We're going to send you a new bill and it's going to be delineated very well and the price is going to be delineated, everything. You know, this is the first depo I've ever had like this. This is ridiculous, because most of the time, the depos come in and it's what did the patient have, how did it happen, what's the diagnosis and all that. You're not even interested in that. All you're doing is concentrating on the amounts.

Well, these amounts are wrong. You're going to get another one and if they don't pay the other one, I'm going to bring suit, okay? And you have started that and it's because of you, and I'm going to put that in my letter. You're the one who really showed me that I was wrong.

* * *

Q. Additionally, Doctor, I'm looking at -- This is part of the composite exhibit. This is the second page of this health insurance claim form.

A. You want it stapled or --

Q. No, it's fine. And the dates of service there reference 1-4-95 and 1-10-95?

A. Where are you reading the dates?

Q. That would be the next dates of service right after 12-30-94. It would be the second -- Right. That should be -- Right there.

A. Okay. Right. All right.

Q. And again, it was for CPT code 97014?

A. Correct.

Q. For physiotherapy?

A. Correct.

Q. And again, the charge there was $55?

A. Correct, as listed.

Q. And that says for one day, or you say one day?

A. <u>Well, it says one</u>.

Q. It's not clear whether it's one day or one unit?

* * *

> THE WITNESS: But as I tell you, we don't do it per unit. We do it per day. But actually, <u>what we could do for the future, and we certainly will, is put down how many units</u>.

(D 38-41).

* * *

Q. -- it only lists one diagnosis code. That still doesn't indicate whether it

was one or two units, does it?

A. Where is my diagnosis code?

Q. That's Column D.

A. Column which?

Q. I'll show you so you don't have to -- Right here. That's still only one --

A. I'd have to look that up. I don't know. One, it says 923, and the other one, 840.8. I don't know what that means. You want me to look it up or have the girl look it up right now? Why is one different than the other, then there's three that are blank?

Q. I don't know.

A. Well, you don't know and I don't know, so obviously it doesn't mean one; it means something else.

Q. But you're stating -- Why are you going to revise your bill then?

A. Because they said I only had one unit and we have two units.

Q. So you need to make it more clear?

A. That's right.

(D 47).

* * *

A. Actually, this would have never come to this if they would have known it was two units. Then they would have paid more. If they paid $36 for one unit, they obviously would have paid much more for two.

Q. More than what you would have billed?

A. Yeah.

Q. Absolutely.

A. Right. So therefore, whoever made this error, which we're just as responsible as they are, it wouldn't have come to all this depo.

Q. I know.

A. I mean, that's the whole answer right there.

(D 50).

Dr. Struhl candidly admitted that his office had not come up to the age of computer billing and still did hand billing (D 71). Although Dr. Struhl admitted that he bills based upon the number of body parts treated, there was no fathomable way that Allstate could have known this to be the case, until Dr. Struhl testified to this at the deposition (D 79).

Dr. Struhl acknowledged that the Explanation Of Benefits, sent with the Allstate draft, indicated that his charges for the electrical stimulations exceeded the reasonable amount for the procedure (D 82). Although Dr. Struhl stated that he never received any documents or phone calls from Allstate regarding his bill, there was no reason he would have, because, as evidenced by Dr. Struhl's testimony, there was no way Allstate could have even considered that his $55 bill was for two units (D 82).

Since for the first time, on November 14, 1995 the claim was made for the additional units or treatments of electrical stimulation, Allstate paid the $106.40, claimed by Dr. Struhl at that time of his deposition, within 30 days of November 14, 1995 (R 428; T 4). The Plaintiff continued to litigate her case against Allstate, apparently under the theory that the original bill for $710 from February of 1995 had not been paid in full timely, constituting a wrongful withholding of benefits and she re-noticed her case for non-jury trial several times (R 266; 296;

297; 298; 332; 335-336).

By the time of the non-jury trial held on July 31, 1997, the only issue left was whether the Plaintiff was entitled to attorney's fees under § 627.428, based on the Plaintiff's claim that Allstate had not complied with the PIP statutes and forced her to litigate her claim for the untimely payment of the $106.40 (T 3-5). The only factual and legal issue to be resolved by the court by that point in the litigation was the Plaintiff's entitlement to attorney's fees, if the court found, based on the evidence in the Record, that Allstate had not timely paid for the unclaimed units of treatment and/or if there was an unreasonable, or improper reduction in the payment of the bill (T 5-7). The Defendant had already filed a Memorandum of Law supporting denial of the Plaintiff's entitlement to fees, which outlined all the facts regarding the dispute over Dr. Struhl's bill and the fact that he made no claim for the additional treatments until November, 1995; which was the first time that anyone was aware of the fact that the $55 per treatment was actually for <u>two</u> units or treatments, which amount was then promptly paid, as Allstate had received reasonable notice of a covered loss (R 314-326).

The Plaintiff began trial by claiming that the payment of the remainder of Dr. Struhl's bill, representing the second set of treatments, was a confession of judgment and, as a matter of law, she was entitled to attorney's fees. The Plaintiff simply argued that the entire 80% of the $710 bill submitted in February, 1995 was not paid until November, 1995; which was beyond the statutory 30-day period entitling the Plaintiff to

fees (T 7-11). Allstate outlined its position, explaining that it had been billed $55 per unit of electrical stimulation; it paid a reasonable amount based on what the doctor had submitted to Allstate; and then when it was later discovered during the testimony of Dr. Struhl that, in fact, he was billing $55 for <u>two units</u> of electrical stimulation, Allstate immediately paid 80% for those extra units of therapy and, therefore, there was nothing triggering the Plaintiff's entitlement to attorney's fees and there was no confession of judgment (T 12-21).

The court restated Allstate's position that when the original bill was submitted, a reasonable rate was paid for one unit of billing under Code 97041; which was paid; the doctor never asked for a reason why it was reduced; the doctor admitted that he had billed incorrectly and had not delineated that each $55 amount was for two units of treatment and not one; that Allstate did not receive notice of these supplemental units of treatment until the doctor's deposition and then the money was paid within 30 days of that date (T 21-23). The Defendant went over the various forms submitted, which were exhibits at the trial, and pointed out that, under Florida law, attorney's fees could not be awarded unless there had been a wrongful withholding of benefits, which there clearly was not in this case, as a matter of Florida law, and each bill was paid within 30 days and the Plaintiff was not entitled to fees, costs, or interest (T 24-28).

The Plaintiff told the court that she did not file suit just to get the nominal interest that was due based on the initial

payment made in April, 1995 by Allstate; but rather, in fact, sued to get the $106.40, which was the amount due on the second set of treatments, at which point the court then asked if the Plaintiff was waiving her claim to the nominal amount of interest and the Plaintiff stated that she would have never filed suit over the interest, but sued only because Allstate refused to pay the full 80% (T 32-38). The Plaintiff went off on a tangent, talking about how Allstate determined the reasonable amount to pay on submitted claims; the computer program Allstate used; its failure to determine whether $55 was a reasonable amount for one unit, etc. (T 32-38).

The trial judge then went through a lengthy question and answer procedure with the Plaintiff, going over the various forms; what had been marked on the forms by the doctor; and the portions of Dr. Struhl's testimony the Plaintiff was using to bolster her theory that anybody looking at the HICF form would know that the doctor was charging $55 for two units, even though the Form said $55 for one unit (T 38-46; A 4-5).

The Defendant then pointed out that based on the pleadings in the case and the Answers to Interrogatories, the only amount that was being sought was the $106.40, and not any interest due for any late payment initially made by Allstate; with the Plaintiff then announcing on the Record that she was not seeking money for interest on the first payment made, but still refusing to say that she actually waived that claim (T 47-50). Therefore, the judge finally got the Plaintiff to agree, at least for purposes of the non-jury trial, there was no claim for any

interest on any late payment made in April of 1995 (T 50).

Defense counsel and the court then went through all the various exhibits, showing the claim for $55 per unit, or per treatment; the code designations; the diagnosis contained on the papers; again, the deposition testimony of Dr. Struhl that he had simply billed the amounts wrong, on the forms he sent to Allstate; that there was no need to investigate anything further, based on the original forms submitted; and that the claim, once it was made by the doctor in November, was paid within 30 days (T 50-68). Therefore, the Plaintiff was not entitled to fees, cost, or interest (T 68).

The trial judge made the following findings of facts and conclusions of law:

> THE COURT: All right. I have heard considerable amount of evidence and argument on that evidence, kind of in a rolling and mixed fashion, and I appreciate the preparation of the attorneys and their excellent presentations. Now it falls to the Judge to rule.
>
> My first observation: We have a person who acts as an adjuster on this file. This person is not a doctor, is more of an administrator. This adjuster might find cause to send out for a paper review to outside agency, or right on the face of a claim form might find cause for concern about paying the claim or that portion of the claim which is appropriate under the PIP contract for insurance.
>
> This requires some analysis about who has duties to do what, and if there are duties, when. In this situation the initial -- call it a responsibility or duty, is on the Plaintiff. You can't have any prayer of recovery on an insurance policy unless you make a claim, and I find that as evidenced by the Health Insurance Claim Forms, the HICF

form, the Plaintiff did that, thereby putting the Defendant, Allstate, on notice that something was owed. When the HICF form was put into the hands -- or the forms -- was put into the hands of Allstate in this case, we are talking about an adjuster whom may or may not, I don't thing it's relevant, have one file to look at or may have a thousand files to look at in a day and can reliably look at what is requested.

So in this case -- if I can look at the one that you had as I think Plaintiff's 1. Mr. Gampel hands me what was Plaintiff's 1, today's hearing. Is the Allstate adjuster able to look at this and say, okay, there is some injury, there is some treatment? Yes, they can say that. On the face of the document it appears that the diagnosis code refers to one modality. There is a clear ambiguity in the form in Column F, whether it's days or units, and that's unfortunate.

But that ambiguity is cleared up by the diagnosis code, so that -- and I don't have the expertise, but on the arguments that were given by counsel, the Court has grounds to rely on that these diagnostic codes are not generic for all parts of the body but are specific to parts of the body. So here is an adjuster looking at charges are $55 for a single modality. That in itself is reasonable proof to deny coverage at that juncture in time, even though the adjuster and the Defendant herein were advised that there were two separate areas and even though it may be a common sense assumption by a doctor that electrical stimulation or hydrotherapy, or whatever else needs to be done, would be done in one day for the convenience of the doctor and the patient. The adjuster doesn't have that kind of expertise. The adjuster is just clicking off the numbers and comparing a diagnostic code, looking at a number of units and the charges that are there charged, and then can see, well, there is a problem.

There has been pled in this case an affirmative defense going to the reasonableness. Reasonableness under the Statute isn't clearly defined, it could be reasonableness of a procedure, it also could

be reasonableness as to a charge for a particular procedure, and on the face of this HICF form, it appears to an objective standard, an adjuster in this industry and trade and practice in this industry, that it's one unit, one modality, a clear -- it appears, to that type of reading, it's an overcharge. And a payment was made and apparently accepted, although Plaintiff contends that a running deficit was growing so that it totaled at least $106 by today's juncture in principal claim.

Now, there is a concern that is brought up in the Pacheco case. This Court is convinced on argument and the evidence as presented, that Pacheco can be distinguished. Allstate in this case paid the claims within the 30-day period upon the evidence they were given at the time the claim was made, specifically, the HICF form. It is central, some wise person once said that when you have a conflict between two, more often than not, one side or the other has a false premise, and there is some false premise here about whether this was for two units or one unit. The claims adjuster and the Defendant have a right to rely on the HICF form as presented and do not have to look beyond it unless they're given notice of their error.

My concern goes to whether or not this is indeed a confession of judgment.

My finding is that it is not technically a confession of judgment. This is a payment on the policy within the 30 days of becoming aware and when Allstate became aware that it was two modalities, two areas of the body that were being billed and that $55 indeed was a reasonable charge for those treatments.

The Statute, 627.736, and I think -- what was the 4, point 40?

* * *

THE COURT: 428, okay, thank you. Provides for an award of attorney's fees if Plaintiff prevails on the claim. As I have already announced that the payment of $106, although made during the pendency of this claim, was not a confession of judgment, rather a payment on the policy, I have to

find the Plaintiff has not prevailed on this claim and is not entitled to their fees. I don't know if 726 -- 627.726 provides for costs and fees or if costs are expressed in another section, but in any event, costs generally are to the prevailing party and my ruling holds for the costs as well as for entitlement of fees.

* * *

THE COURT: I am envisioning an administrator, an adjuster, they're not even going to look at the entire file and spend days researching the law and researching and consulting with doctors, they're going to go: One unit of diagnosis code, must be a unit, the charge is $55. Let's look at the physician code book on reasonable charges in Dade County. This is a little bit high, they send the check.

They don't think anything is wrong, they think that the doctor made a mistake and it was accepted. Your concern is, well, they have a duty of investigation. That's the insurance company.

* * *

THE COURT: All right. Let me then limit my ruling as follows. My ruling is underpinned or grounded on the assumption that a reasonable charge for one electrical stimulation to one area of the body is less than $55 and within the range of what a physician code -- a physician, what is the technical code of that book? There is a book that they have.

(T 83-91).

* * *

THE COURT: I will clarify, the Court's ruling is only as good as the evidence that is presented, and the evidence as presented today is that the good doctor, Struhl, understood that $55 would be a reasonable charge for two modalities, and the Court's ruling today is that the HICF form, which was the genesis of all the misunderstandings, seems to show one modality, one unit for each charge, for a reasonable adjuster who is an administrator for purposes of paying PIP claims.

(T 94).

* * *

> THE COURT: A final matter that was discussed while off the record, and I want to add it in for the protection of the parties, is I used an analogy regarding the phone having ability to not only receive calls but to send calls. Plaintiff complained that the duty to have what amounts to a duty to investigate the claimed $55, the Court made a finding that -- or hereby makes a finding that on the face of the claim forms, the HICF form, there was reasonable proof in front of them that one modality was charged in excess, i.e., an unreasonable charge, and I was explaining to Mr. Gampel that when that happened, the doctor or the Plaintiff, through counsel or otherwise, could have called up and said, just as easily as receiving the phone call, could have called up and said "Why," Plaintiff could have asked why this was less, and that all of these problems could have been cleared up at an early, very early stage.
>
> The Court's finding is that Allstate Insurance in this case, their duty to investigate further -- there was no such duty based on the HICF form alone. It was sufficient proof to put them on notice that there was a claim but that the charge for the specific, specifically reported treatments was in excess of reasonable charges in the Dade County community, medical community. Okay.
>
> (T 99-100).

The trial court entered an Order denying the Plaintiff's entitlement to fees and costs based on its fact findings and conclusions of law (R 398). The Plaintiff appealed and the circuit appellate court reversed, made a new fact finding without holding that the judge's fact finding was clearly erroneous; and shifted the burden of proof to the Defendant on the PIP claim. Allstate filed a Petition for Writ of Common Law Certiorari on the basis that the circuit court had created new PIP law, it had

created a new standard of review of the trial judge's fact finding after a non-jury trial and had applied incorrect principles of law to the admitted facts; and this had deprived the Petitioner of due process resulting in a miscarriage of justice. The Third District held:

> Farren Ivey ("Ivey") was struck by a vehicle insured by Allstate Insurance Company ("Allstate"). Ivey sought treatment from her doctor, which treatment included physical therapy consisting of unattended electrical stimulation therapy. Ms. Ivey's treatment extended from December 16, 1994 to January 10, 1995. By that time, the overall cost for services totaled $710.00.
>
> Ms. Ivey filed a PIP claim with Allstate and the required Health Insurance Claim Form for payment of the claim. Allstate then made payment to the doctor in the amount of $461.60 together with an explanation of benefits form explaining how Allstate arrived at the total.
>
> Thereafter, Ms. Ivey filed suit against Allstate for medical expenses and routine personal injury damages. Allstate, under the belief that Ms. Ivey's claim had been paid with the exception of the reduction, answered Ms. Ivey's Complaint. During the doctor's deposition, Allstate learned that the bill included two treatments, and not one as reflected on the face of the bill. Upon review of his bill, the doctor recognized that the bill did not itemize the charges and conceded that the billing on the Health Insurance Claim Form was incorrect. Within 30 days of the deposition, Allstate paid the doctor the additional monies owed him. Ms. Ivey continued this action against Allstate under the theory that Allstate's failure to pay the original bill in full constituted a wrongful withholding of benefits requiring her to seek the services of an attorney.
>
> A non-jury trial was held on the issue of whether Ms. Ivey was entitled to attorney's fees under section 627.428, Florida Statutes. The county court judge

made the following findings of fact: Allstate paid the "reasonable rate" for one unit of billing; the bill was ambiguous as to whether it reflected one or two units of treatment; the doctor did not question the reduced payment; the doctor admitted the bill was unclear and that Allstate's belief was reasonable; Allstate did not learn of this until the doctor's deposition; the balance of the bill was paid within 30 days of Allstate's notice of the error. The court found that Allstate and its claims adjuster had a right to rely on the Health Insurance Claim Form without having to look beyond it unless given notice of an error, and accordingly, denied Ms. Ivey's entitlement to fees and costs. On appeal, the Appellate Division of the Circuit Court reversed.

Because we find that the Appellate Division of the Circuit Court departed from the essential elements of law, we grant the Petition for Writ of Certiorari. The circuit court relied on *Fortune Ins. Co. v. Pacheco,* 695 So.2d 394 (Fla. 3d DCA 1997) and *Martinez v. Fortune Ins. Co.,* 684 So.2d 201 (Fla. 4th DCA 1996) as a basis for reversal. However, both of those cases are distinguishable from the instant case. In those cases, the carrier failed to recognize and verify the claims within the 30 days, to wit, the carrier simply held the payment of claims until they received "proof" of the loss. In the case at hand, however, Allstate recognized and paid the "reasonable" cost of the services described in the bill.

Section 627.736(4)(b), Florida Statutes, requires that benefits due from an insurer be payable within 30 days after the insurer is furnished written notice of the fact of the covered loss and the amount of the claim. Section 627.736(5) requires that a physician, hospital or clinic charge "only a reasonable amount for the products, services, and accommodations rendered" to individual covered by PIP insurance.

Allstate properly paid the "reasonable" cost of one unit of treatment as provided by Ms. Ivey's doctor. Allstate made payment on Ms. Ivey's claim based on what a "reasonable" charge would be per unit of treatment. Ms.

Ivey's doctor admitted that the bill, on its face, seemed to be for only one unit of treatment. Additionally, Allstate paid the balance of the bill within 30 days of learning that the total amount of the bill included two units of treatment. Because Allstate did not pay the entire claim due to an error in the doctor's bill, its failure to pay said claim does not rise to that level of "wrongful" which would entitle Ms. Ivey to an award of attorney's fees. Fla. Stat. ss 627.736(8), 627.428; *see also Obando v. Fortune Ins. Co.*, 563 So.2d 116 (Fla. 3d DCA 1990). Accordingly, we reverse.

The Petition for Certiorari is granted, the decision of the Appellate Division of the Circuit Court is quashed, and the case is remanded to the Circuit Court for Dade County, Appellate Division with directions to enter an opinion affirming the County Court judgment.

Ivey, 282-283.

SUMMARY OF ARGUMENT

The Plaintiff would like to turn this into a case, where Allstate failed to verify or investigate a claim within 30 days, so that her case law would be in conflict with the Ivey, supra, decision. Of course, this completely ignores the trial court's fact findings, that Allstate had no reason to suspect that the doctor was billing for anything other than what his report/bill and HICF form indicated (A 3-5); the doctor admitted that he had billed incorrectly; the doctor admitted that the papers reflected 5 treatments at $55 per unit; the doctor admitted his forms were wrong; and it was only in November, 1995, during his deposition, that the doctor announced for the first time, that $55 represented two units of treatments, not one; and it was at that point during his deposition that he made a claim for the additional $106.40 in treatments and was promptly paid. The ambiguity in the forms was that the doctor's report/bill first sent to Allstate, showed "5 x $55" treatments and then on the next line $110 was billed, which was taken to mean "2 x $55;" so the bill showed, at best, a total of 7 treatments, not 14 (A 3).

The trial court's express findings of fact and conclusions of law, as well as the Third District's Opinion are totally ignored by the Plaintiff, so that she can use her cases to claim that the payment for the additional treatments constituted a confession of judgment on the part of Allstate. The trial court expressly ruled there was no confession of judgment; the trial court expressly found that this claim was not made until

November, 1995 and was paid <u>within</u> 30 days; the judge found that this could not be a confession of judgment and totally rejected the Plaintiff's cases and arguments on this point. The circuit appellate court expressly did not rule on this legal issue. The Third District properly, using the correct legal standard, reinstated the trial judge's rulings; and the Plaintiff did not cross-appeal the circuit court's refusal to rule on the confession of judgment argument.

Allstate showed that the circuit court panel deviated from the essential requirements of the law and did not use the correct law when it created new PIP law; shifted the burden of proof; and substituted its fact finding for that of the trial court. The Third District used the absolute correct standard of review under <u>Haines</u>, <u>infra</u>, and its Opinion must be affirmed.

The Plaintiff is simply rearguing her case for the fifth time, which has been rejected four times before and there is no conflict for this Court to resolve, nor law to correct; and this Court should find it does not have a legal basis to reverse the Third District's decision and its standard of review. The <u>per se</u> payment rule espoused by the Plaintiff and Amicus should be rejected, as it violates Florida's PIP statute and they have failed to cite any law or reason to apply the <u>per se</u> PIP payment rule to attorneys' fees as well. The decision in <u>Ivey</u> must be affirmed.

ARGUMENT

I. THE THIRD DISTRICT APPLIED THE CORRECT LEGAL STANDARDS IN REINSTATING THE TRIAL JUDGE'S ORDER AFTER A NON-JURY TRIAL, THAT PAYMENT WAS TIMELY MADE AFTER ALLSTATE RECEIVED NOTICE OF THE CLAIM AND THE DECISION IN IVEY MUST BE AFFIRMED.

This is not a case of an insurance company not timely "verifying" a claim. Rather, as expressly found by the trial court, the initial claim was properly evaluated and properly paid; the doctor never contacted Allstate after receiving the reduced bill and Explanation of Benefits; nor was there any indication from anyone that the bill was not exactly what it represented; and at the later date, when the doctor claimed additional treatments, Allstate again, in good faith, immediately paid them.

The fact that Ivey had two or three injured areas of her body would not put Allstate on notice that it had to comb through all of Ivey's medical charts to see that what was billed and coded as a single unit of treatment was really two units of treatment. The whole purpose in using standard codes and columns asking for the number of units of treatment is to speed up the process so claims are promptly paid; the code and unit column showed one unit per $55 billed. There was nothing to alert Allstate to Dr. Struhl's admitted mistaken billing. Mrs. Ivey did not pay this $106.40. She sued Allstate and when it was discovered that Struhl was to be paid for two units per day for 7 days, he was paid the $106.40. The Plaintiff was not out any money and was never billed for $106.40. Now she wants an

automatic payment of fees and costs, because Allstate should have known about the conceded billing error; and because it paid 30 days from Struhl revealing the extra units; instead of 30 days from the PIP claim (which only showed single units, (A 3). The Plaintiff was not damaged and her doctor was promptly paid. He even admitted that the reduced rate paid by Allstate was higher, than what he charged his patients.

The Plaintiff in this case asked for and received a per se legal ruling from the circuit court, that, in spite of the facts and evidence presented, if 80% of a PIP bill is not paid within 30 days, the Plaintiff is entitled to attorney's fees and that is all there is to it. Not only is that contrary to the facts and evidence presented in this case, but there is no legal support for this conclusion, as well. The trial judge was given Deposition testimony, reviewed the exhibits, the medical report, reviewed the Defendant's Memorandum of Law, and, after a non-jury trial, found that there was no late payment, under the PIP statute, to entitle the Plaintiff to fees and costs. The judge went to great length to set out his fact findings and legal conclusions, which were summarily dismissed by the circuit court, without any finding that the trial judge was clearly erroneous.

Under the proper standard for review of this case, the Judgment below must be affirmed. There was ample evidence in the Record to support the court's Order after the non-jury trial; and that the fact findings and legal conclusions of the trial court were never shown, nor found to be, clearly erroneous, based on that Record evidence. The circuit court did not even mention the

bulk of the evidence presented to the trial court; nor did it even acknowledge the judge's fact findings. Rather the circuit court ignored the principles of law it should have applied to the facts; and not only reversed the trial judge, but shifted the burden of proof to the insurance carriers for PIP cases. According to the Plaintiff, the insurance company has to be clairvoyant and know a mistake exists, on an otherwise unremarkable bill (A 3, 4-5). The Plaintiff and Amicus want each insurance carrier to match each and every amount, code, etc. on every PIP bill and with all the plaintiff's medical records, to ensure that the provider did not make a billing error. That certainly is not what the Legislature and Third District meant when they required a claim to the "verified." At trial the doctor admitted his form did not even have a space to bill multiple modalities, which is why he only billed per single unit. To place the burden on PIP carriers to correct the type of form chosen and submitted, or correct admitted mistakes by providers, is not based on any law in Florida; which is why the circuit court was reversed; the right law and legal standards were applied and the Final Judgement was reinstated. Ivey, supra.

The Plaintiffs' Bar wants an automatic payment of 80% of all medical bills and even if a plaintiff does not pay the amount in dispute, or has assigned her PIP benefits to the provider, there is still an automatic award of fees and costs, when that 80% does not arrive at the doctor's door in 30 days. Florida courts are buried in PIP cases, where plaintiffs and providers are trying every device possible to avoid mandatory arbitration of these PIP

claims, to get fees. Plaintiffs are trying to revoke assignments, so they can sue and get fees; even when an irrevocable assignment exists and the plaintiff has not paid a dime in medical bills, like Ivey. Plaintiffs want the carriers to pay their providers directly, but also want the right to fees at the same time and to ignore the PIP statute and their own insurance policies. The plaintiffs should lobby the legislature if they want a flat, automatic 80% payment and for the per se fee award they are asking this Court to adopt. However, at this point in time the insurance companies are bound by the PIP statute to pay 80% of "reasonable and necessary" medical bills and that is exactly what Allstate did in this case, as the trial judge ruled and the Third District affirmed. Any new law should come from the legislature and not this Court and the decision in Ivey must be affirmed.

A. Plaintiff and Circuit Court Applied Wrong Standard of Review

In a non-jury trial, the trial court's decision comes to the court of appeal clothed in a presumption of correctness and the judge's fact finding cannot be reversed unless clearly erroneous. Since Ivey could not overcome this burden, she instead argued for a per se entitlement to fees, because the original bill was not paid in full within 30 days; even though the trial court, sitting as fact finder, totally disagreed with the Plaintiff, as did the Third District. Ivey's burden was to prove that there was no evidence to support the Final Order; but an abundance of such evidence existed; there was no basis for

reversing the trial court's findings; and the circuit court just substituted its fact finding and conclusions for the judge's.

The findings of the trier of fact will not be reversed on appeal if there is any evidence to support it after a trial on the merits. Harbor Yacht Repair, Inc. v. Sanger, 279 So. 2d 64 (Fla. 3d DCA 1973). The conflicting testimony and evidence in the present case were properly sorted out by the trial judge as trier of fact and his detailed decision was based upon the evidence presented at trial, as he expressly outlined; and the circuit court did not find that the judge's ruling was clearly erroneous.

Where evidence, although conflicting, in a non-jury trial is not shown to be clearly erroneous, the trial court's findings will not be disturbed. Mori v. Matsushita Electric Corporation of America, 380 So. 2d 461 (Fla. 3d DCA 1980).

A trial judge sitting without a jury is responsible for reconciling inconsistent and conflicting evidence and his findings thereon will not be disturbed by the appellate court unless clearly erroneous. Pokress v. Josephart, 152 So. 2d 756 (Fla. 3d DCA 1963). Again, it is well settled that a trial court's findings in a non-jury trial come to the appellate court clothed with a presumption of correctness; and the circuit court could not disturb the trial court's findings, absent a showing that they are clearly erroneous. Hill v. Coplan Pipe & Supply Co., Inc., 296 So. 2d 567 (Fla. 3d DCA 1974); Pokress, 756.

The trial judge's findings of fact are entitled to the same weight as is given to findings of the jury and will not be

disturbed by an appellate court unless such findings are clearly shown to be erroneous. Marsh v. Marsh, 419 So. 2d 629 (Fla. 1982); Strawgate v. Turner, 339 So. 2d 1112 (Fla. 1976); Trace v. Nicosia, 265 So. 2d 88 (Fla. 2d DCA 1972). Further, where a case is tried before a trial judge without intervention of a jury, an appellate court will ordinarily refuse to consider a finding of fact made by the trial judge again, unless it is shown to be clearly erroneous. Vail v. State, 205 So. 2d 536 (Fla. 3d DCA 1968). The Vail court further elaborated on this principle by stating that in testing the accuracy of such conclusions, the appellate court should interpret the evidence and all reasonable inferences and deductions capable of being drawn therefrom in the light most favorable to sustain those conclusions. Vail, supra. The circuit court did not apply this standard and it was properly reversed.

B. Judge's Finding Clearly Supported

Dr. Struhl admitted that his bill and the claim Form sent to Allstate only indicated 5 treatments at $55 each; that he was wrong in billing in this manner; and the judge expressly found that Allstate properly took this Form as a claim for single units of treatment. Allstate did not "assume" anything, but rather relied on the undisputed bill submitted by the doctor, who admitted that Allstate properly reduced his bill based on what he submitted; and any "mistake" was his. The judge also expressly found that the claim was properly reduced to a reasonable amount per unit of treatment; and it was not even until Dr. Struhl's

testimony in November of 1995, that anyone, including the Plaintiff knew that each $55 amount represented two treatments, not one. Once Dr. Struhl made his claim for the additional treatments, he was promptly paid within 30 days. There was nothing under the facts and evidence in this case to trigger any penalty provision contained in the PIP statute; so the circuit appellate court created new law; which the Third District reversed. Ivey, supra.

It is important to note that this is not a situation involving a claim of tolling of any 30-day provision; nor does it involve any refusal to pay the amounts claimed. The pertinent language of the PIP Statute, § 627.736(4)(5), Fla. Stat. (1993), at issue here states as follows:

> **(4) Benefits; when due.—**Benefits due from an insurer under ss. 627.730—627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issue under ss. 627.730—627.7405.
>
> * * *
>
> (5) **Charges for treatment of injured persons.**
> (a) Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge only a reasonable amount for the products, services, and accommodations rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment ... In no event, however, may such a charge be in excess of the amount the person or

> institution customarily charges for like products, services, or accommodations in cases involving no insurance ...

The specific language of the PIP statutes put the burden on the insured to produce reasonable proof of the loss in order to receive payment. The purpose of the proof and notice is to allow an insurer to form an intelligent estimate of its rights and liabilities and to afford it an opportunity to investigate and prevent fraud. Even the doctor, who wrote the medical report and sent out the bill and HICF form, was unaware of this mistake until after suit was filed. However, a sanction is being sought from the insurance company that relied on the standard proof provided.

The trial judge expressly found that the claim was made by Dr. Struhl in November and paid within 30 days, which finding does not trigger any attorney's fees award under any of the Plaintiff's cases.

The cases cited by the circuit appellate court were completely off point because this was not a situation involving the 30-day payment provision being tolled; nor did the insurer need more than 30 days to verify the claim. There was a $106.40 claim and the judge ruled it was made in November, paid in December and, thus, was not an overdue PIP payment triggering the attorneys' fee sanction.

Fortune Insurance Company v. Pacheco, 695 So. 2d 394 (Fla. 3d DCA 1997) simply holds that the benefits, when claimed, must be paid within 30 days of receipt of the claim and not within 30 days of receipt of the medical verification of the claim. The

trial judge in this case expressly found no claim for units of electrical stimulation therapy beyond the first 7 units claimed in Dr. Struhl's bill and HICF form (A 3; 4-5). The judge expressly found the claim was paid within 30 days and nothing in Pacheco changes that factual or legal result.

In Pacheco, the insured notified Fortune of his accident and on January 25, 1995, filed a claim letter, medical bills in the amount of almost $6,000, along with other documents. Pacheco, 395. Fortune forwarded the medical records to a reviewing company, which then requested additional information. Fortune did not pay any of the claim until after the 30 day deadline, and only after Pacheco had filed suit for his PIP benefits. Pacheco, 395. The defense to Pacheco's lawsuit by Fortune was that Pacheco, at the time he claimed benefits, had to provide all supporting records and only when all the full verification of the claim was made, did the 30 days begin to run. This Court expressly disagreed with the insurance company's defense, finding that the insurance company's attempt to create its own means of tolling the statutory period was to no avail. Pacheco, 395-396. In Pacheco there was absolutely no payment of the medical bill whatsoever within 30 days; nor was there any issue that the bill included unclaimed treatments not appearing on either the bill, nor the HICF Form. Pacheco is completely off point and can not establish that the Order of the trial court was clearly erroneous.

Similarly, in Martinez v. Fortune Insurance Company, 684 So. 2d 201 (Fla. 4th DCA 1996), the Fourth District came to the

same conclusion that the no-fault carrier was required to verify a claim for wage loss and benefits within 30 days of receipt of the claim and that 30 day period was not tolled, while medical verification of the claim was received from the insured. In fact, in Martinez, the court noted that the plain language of the statute indicates that the carrier is only obligated to pay when it receives reasonable proof of a covered loss and that the obligation to pay for PIP benefits is based on a receipt of written notice of a loss, rather than proof of loss. Martinez, 203. In the present case, the notice of the $106.40 loss was not given to the carrier until Dr. Struhl's deposition; when it came to light for the first time that, in fact, the $55 claimed per treatment by Dr. Struhl was, in fact, $55 for two treatments. Once Allstate was on notice of the doctor's admitted mistake, it paid the claim within 30 days. Therefore, neither Pacheco or Martinez called for any different result than what the trial court arrived at below.

The Third District agreed that these cases were distinguishable because the carriers withheld payment until they received "proof of the losses," which did not occur within the 30 day payment period. Ivey, 283. However, when Allstate received Struhl's report/bill and HICF Form it paid the "reasonable" cost for the services described. Ivey, 283. In fact, Dr. Struhl admitted that Allstate's payment for each single unit of therapy was higher then what he actually charged Mrs. Ivey. Therefore, the Third District found that the circuit court had erroneously found a wrongful withholding of benefits triggering the

attorneys' fees sanction under § 627.428, Fla. Stat. (1983) and quashed that decision and reinstated the trial judge's findings after the non-jury trial. Ivey, 283.

Below Allstate relied on Obando v. Fortune Insurance Company, 563 So. 2d 116 (Fla. 3d DCA 1990) for the principle that the courts in Florida have held that for an insurer to be held liable for attorney's fees, there must be a wrongful withholding and/or delay in payment. The circuit court changed the law to hold any delay in payment, means the carrier must be sanctioned by paying fees and costs.

More egregious was the circuit court's finding that the lack of a "minimal inquiry" triggers a fee award; when it was undisputed that there was nothing to put Allstate on notice, that any inquiry at all was necessary; and certainly nothing to impose an accounting duty on Allstate to check and ensure that all the doctor's bills matched up with what he did; nor did Allstate have a duty to redesign the doctor's office forms to make sure his billing mistakes were avoided.

The Florida courts are in total agreement with the Third District that in order for an insurer to be liable for attorney's fees under § 627.428, the express fee statute listed in the PIP statute, there has to have been a **wrongful** withholding of benefits; and the trial and district courts found that Allstate acted in good faith. § 627.736(8), Fla. Stat. (1993) states:

> **(8) Applicability of provision regulating attorney's fees.**—With respect to any dispute under the provisions of ss. 627.730—627.7405 between the insured and the insurer, the provisions of s. 627.428

shall apply.

This Court held that for an insurer to be liable for attorney's fees, there must be a **wrongful** withholding and/or delay of payment. Obando, supra; New York Life Insurance Company v. Shuster, 373 So. 2d 916 (Fla. 1979); Manufacturers Life Insurance Company v. Cave, 295 So. 2d 103, 104-106 (Fla. 1974); Equitable Life Assurance Society of the United States v. Nichols, 84 So. 2d 500, 502 (Fla. 1956); Fortune Insurance Company v. Iriban, 593 So. 2d 598, 599 (Fla. 3d DCA 1992).

An insurance company must pay attorney's fees only if the company wrongfully caused the parties to resort to litigation by not resolving the conflict when it was reasonably within the company's power to do so. Crotts v. Bankers and Shippers Insurance Company of New York, 476 So. 2d 1357, 1358 (Fla. 2d DCA 1985). The Plaintiff and the circuit court believe that an insurance carrier must audit every provider's file and records within 30 days, to uncover billing mistakes or the insurance company will be sanctioned.

The Crotts' court stated that "because the conflict in the case involved the resolution of factual and legal issues which the insurance company could not reasonably expect to resolve on its own, the insurance company was not wrongful in withholding payment and forcing the case into court." Crotts, 1359. Similarly to the Crotts' case, the instant case involved factual issues that Allstate could not have reasonably been expected to resolved on its own; especially where the doctor admitted that Allstate properly reviewed his bill and HICF form and reduced it

according to community standards. Florida courts also agree that there cannot be a wrongful refusal or delay in benefits, when claim at issue involved a factual dispute which the insurer was unable to resolve by itself. Ray v. Travelers Insurance Company, 477 So. 2d 634 (Fla. 5th DCA 1985).

The courts have also held that the purpose of § 627.428 is to penalize a carrier for wrongfully causing its insured to resort to litigation. Government Employees Insurance Company v. Battaglia, 503 So. 2d 358 (Fla. 5th DCA 1987). It is important to remember that Dr. Struhl never challenged the payment he received from Allstate; Mrs. Ivey was never billed for any under payment; and Mrs. Ivey never paid the $106.40; that according to her was apparent to anyone looking at her records. Mrs. Ivey was never damaged and she was not forced to litigate out-of-pocket money that was owed to her. Dr. Struhl made several clerical mistakes and he was promptly paid when he discovered them. This is not a basis for § 627.428 fees.

When the claim is one that the carrier reasonably can expect to be resolved by a court, rather than by itself, then § 627.428 does not generate a punitive fee. Battaglia, 360. Public policy dictates that an insurer should not be penalized for the negligent actions of the insured, or the improper forms or office procedures of a provider.

Additionally, a PIP insurer has thirty days from being "furnished written notice of the fact of a covered loss and of the amount of same" to make payment. Ledesma v. Bankers Insurance Company, 573 So. 2d 1042, 1043 (Fla. 3d DCA 1991). The

Ledesma court correctly denied attorney's fees because Bankers paid the benefits within thirty days after being furnished with notice of the fact of a covered loss. Ledesma, 1043.

The circuit court below wanted a different result, so it created new law and standards of review; making a new fact finding that Allstate failed to "verify" the claim within the original 30 days and shifting the burden of proof to the carrier to prove its payment. This is not a case of an insurance company not timely "verifying" a claim. Rather, as expressly found by the trial court, the initial claim was properly evaluated and properly paid; the doctor never contacted Allstate after receiving the reduced bill and Explanation of Benefits; nor was there any indication from anyone that the bill was not exactly what it represented; and at the later date, when the doctor claimed $106.40 in additional treatments, those were immediately paid.

The circuit court completely mischaracterized and ignored the evidence and issues below, to support its reversal. According to the Plaintiff and Amicus, a PIP carrier has to comb through the insured's entire medical file, to ensure that some provider has not overlooked billing the right amount of money, otherwise the carrier will be in violation of the PIP statute and be sanctioned with fees payment. No case in Florida has ever held this. The Opinion of the circuit court unquestionably deviated from the essential requirements of the law; it was properly quashed; the trial judge's rulings were correctly reinstated, under the proper standard of review; the District

court's Opinion in Ivey must be affirmed.

II. THE TRIAL COURT EXPRESSLY FOUND THERE WAS NO CONFESSION OF JUDGMENT; THE THIRD DISTRICT APPROVED THIS RULING; THE PLAINTIFF HAS GIVEN THIS COURT NO REASON TO REVERSE AND THE DECISION IN IVEY MUST BE AFFIRMED; AS IT IS NOT IN DIRECT AND EXPRESS CONFLICT WITH FLORIDA LAW.

Once again, the trial court's express findings of fact and conclusions of law, affirmed by the Third District are totally and completely ignored by the Plaintiff, so that she can argue two cases to claim that the payment of the balance of her claim for the additional treatments constituted a confession of judgment on the part of Allstate. The trial court expressly ruled there was no confession of judgment; the trial court expressly found that this claim was not made until November, 1995 and was paid within 30 days; the judge found that this could not be a confession of judgment and rejected the Plaintiff's two cases and arguments on this point. The circuit appellate court expressly did not address this issue, finding entitlement to fees simply because Allstate, in good faith, did not pay the right amount of money sooner. Of course, if Allstate had refused to pay the $106.40, within 30 days of when Dr. Struhl discovered his mistake in November 1995, Ivey would have argued that the PIP statute was violated by non-payment within 30 days. The Plaintiff is putting form over substance in her confession of judgment arguments and certainly Allstate should not be penalized for promptly paying, within 30 days of notice; whether suit was filed or not. Ivey must be affirmed as it is not in direct and express conflict with any Florida law.

The Plaintiff cited two cases for the proposition that when

an insurance company agrees to settle a disputed case, it has in effect declined to defend its position in the pending suit and, thus confessed judgment. However, the cases are factually distinguishable and off point, which is why the trial court expressly rejected them.

Ivey's argument that the Third District's decision is in conflict with this Court's decision in Wollard v. Lloyd's and Companies of Lloyd's, 439 So. 2d 217 (Fla. 1983) is wrong. This Court held in Wollard, that where Lloyd's denied coverage, forcing the insured to retain an attorney and file suit and then on the eve of trial agreed to settle the claim, that this constituted a confession of judgment; which was equivalent to the judgment required under the insurance policy, as a condition precedent, to the award of attorney's fees. Wollard, 218. In addition, this Court was concerned that an insurer could avoid liability for statutory attorney's fees, by the simple devise of paying the proceeds at some point after suit was filed, but before judgment was entered. To avoid this inequitable result, this Court held that when the insurance company agreed to settle the disputed case, which in effect was a determination that it was no longer defending its position, which led to the pending lawsuit, this was the functional equivalent of a confession of judgment, or a verdict in favor of the insured, entitling the insured to attorney's fees under § 627.428. Wollard, 218.

Wollard is factually distinguishable from this case and therefore, no direct and express conflict exists. In this case:

Allstate properly paid the "reasonable"

> cost of one unit of treatment as provided by Ms. Ivey's doctor. Allstate <u>made</u> <u>payment</u> on Ms. Ivey's claim based on what a "reasonable" charge would be per unit of treatment. Ms. Ivey's doctor admitted that the bill, on its face, seemed to be for only one unit of treatment. Additionally, Allstate paid the balance of the bill within 30 days of learning that the total amount of the bill included two units of treatment.
>
> Ivey, 283.

The Third District's decision in this case does not conflict with Wollard in any respect, because Allstate never refused a claim, nor did it settle a claim, after first denying payment. Initially Allstate paid, what the Third District affirmed, was a "reasonable" charge for the doctor's services. However, once the doctor discovered his error and it was revealed to Allstate, Allstate paid the additional amount of the bill within 30 days. There is absolutely no conflict between Wollard and Ivey; therefore there is no express and direct conflict and this Court has no jurisdiction and there is nothing for this Court to resolve.

Ivey also cites as conflict, United Automobile Insurance Company v. Zulma, 661 So. 2d 947 (Fla. 4th DCA 1995). However, Zulma is also factually off-point and not relevant to this case. In Zulma, the issue dealt with IME's; when they were set; and whether or not the plaintiff even knew of the IME, since she could not speak, read or write English. Zulma, 948. When the insurance company found out, during the course of litigation, that the reason that Zulma had missed her scheduled IME, was based on her inability to communicate in English, and she

mistakenly went to her own doctor, believing that is what the insurance company was asking her to do, the insurance company then abandoned its defense of failure to comply with the condition precedent, which was the basis of its denial of benefits in the case. Zulma, 948.

This case is not a situation where the insurer could have reasonably paid the claim for benefits, without causing the insured to hire a lawyer and file suit; because the claim for the doctor's bill was not made until after the litigation was filed and, therefore, there was no confession of judgment in the present case. Unlike Zulma, Allstate, in this case, never denied payment for bills and when Allstate was notified of the billing error, Allstate immediately paid the remaining portion of the bill. Allstate could not have denied payment for bills for medical treatments it never knew were rendered. There can be no direct or express conflict between the Third District's decision in this case and this Court's holding in Wollard, or the Fourth District's holding in Zulma and therefore, this Court had no jurisdiction and no legal reason to reverse the Decision in Ivey; which must be affirmed.

III. THERE IS NO CONFLICT WITH THE STANDARD OF REVIEW FOR CERTIORARI CASES; THEREFORE THERE IS NOTHING FOR THIS COURT TO RESOLVE; AND THE DECISION IN IVEY MUST BE AFFIRMED.

Originally, to establish jurisdiction in this Court, Ivey argued that the Third District did not follow the Fortune Insurance Company v. Everglades Diagnostics, Inc., 721 So. 2d 384 (Fla. 4th DCA 1998) review standard; to find that the intermediate appellate court deviated from the essential requirements of law, because of its erroneous interpretation of the PIP law, which was important enough to invoke certiorari review. Ivey was mixing and matching statements from different appellate court cases in order to try to create some kind of conflict; which she now apparently recognizes as being incorrect; because she does not even cite Fortune in her Brief. Furthermore, it was the circuit court's failure to follow established law; failure to apply the correct standards of review; and its creation of new PIP law; and shifting the burden of proof; that gave the Third District jurisdiction to review that Opinion. This entire Point on Appeal is to distract the Court from what the circuit court erroneously ruled, by claiming that it was the Third District that used the wrong standard of review. Under the right standard of review, as discussed in Point I of this Brief, the trial judge's Order should have been affirmed, as a matter of law. What the Plaintiff wants is a ruling that virtually no circuit appellate court decision is reviewable and it is a court of last resort. However, Ivey has not cited a single case to support that argument. If that legal

principle were true, this Court would have never issued its opinion in Haines, infra; as it would have been totally unnecessary. Review is available by certiorari and the Third District applied the right standard and Ivey must be affirmed.

The very case that Ivey relies on from this Court, Haines City Community Development v. Heggs, 658 So. 2d 523 (Fla. 1995), clearly explains that certiorari review applies to decisions where the procedure used by the lower courts is essentially irregular and not according to the essential requirements of law. Haines, 526.

In this case, the Third District followed Haines, finding that "the Appellate Division of the Circuit Court departed from the essential elements of law" and granted certiorari relief:

> "[G]iven the pervasiveness of automobiles and PIP coverage in this state, we deem an erroneous interpretation of this law to be important enough for certiorari." See Fortune Ins. Co. v. Everglades Diagnostics, Inc., 721 So.2d 384 (Fla. 4th DCA 1998).
>
> Ivey, D390.

The Third District expressly used the same standard set forth in Fortune and this is not an extension of the District Court of Appeal's certiorari review; therefore, no conflict exists. The very basis for certiorari review in this case is that the circuit court panel failed to apply the correct law and created new law; thus, deviated from the essential requirements of law, as described by this Court in Haines, which was sufficient to invoke the Third District's certiorari jurisdiction.

The exact test set out by this Honorable Court in Haines, was followed by the Third District, in that inquiry on certiorari review is limited to whether the circuit court afforded procedural due process "and whether the circuit court applied the correct law." Haines, 530. This Court further explained that these are merely expressions of ways in which the circuit court decision may have departed from the essential requirements of law and this standard contains a degree of flexibility and discretion. Haines, 530-531.

There is no conflict between this case and the First District's holding in Nationwide Mutual Fire Insurance Company v. Hatch, 717 So. 2d 71 (Fla. 1st DCA 1998). Again, Ivey's argument was off-point and totally wrong; which is probably why she no longer relies on this case either; even though she cited it to this Court as being in direct and express conflict. In Nationwide, the First District denied certiorari because the issue concerned a factual basis and not the application of incorrect law:

> The county court found, as a matter of fact, that petitioner waived its right to compel arbitration by engaging in discovery. *See, e.g., Coral 97 Associates, Ltd. v. Chino Electric, Inc.,* 501 So.2d 69 (Fla. 3d DCA 1987). On appeal to the circuit court, petitioner failed to challenge the adequacy of the factual basis for the county court's finding of waiver. We cannot say that the circuit court, acting in its review capacity, failed to afford petitioner procedural due process or failed to apply the correct law.
>
> Nationwide, 71.

There is also no direct and express conflict with the new

case cited by the Plaintiff for the first time, Education Development Center, Inc. v. City of West Palm Beach Zoning Board of Appeals, 541 So. 2d 106 (Fla. 1989)(EDC). In that case an educational center owned residential property and wanted to convert its property to a private school and kindergarten. After the city ruled against it, the Center appealed to the Zoning Board of Appeals. The Board also denied EDC's application; the Center appealed the Zoning Board of Appeals decision to the circuit court. EDC, 107. The trial judge, sitting as the circuit appellate court, reversed the Zoning Board of Appeals concluding there was substantial competent evidence to support the original application of the Center. EDC then sought appellate review in the Fourth District Court of Appeal, which granted its petition for writ of certiorari, concluding that the circuit court judge (appellate court) had applied the incorrect standard of review, when that appellate court reviewed the Zoning Board of Appeals decision. EDC, 107; citing, City of West Palm Beach Zoning Board of Appeals v. Education Development Center, Inc., 504 So. 2d 1385 (Fla. 4th DCA 1987).

The Fourth District remanded for a redetermination by the circuit appellate court, because the circuit court had departed from the essential requirements of law, by applying an incorrect standard of review. EDC, 107. That, of course, is the exact argument made to the Third District below; regarding the circuit appellate court decision. However, unlike EDC, review in the Third District was the second, but not the third appellate review.

The Fourth District instructed the circuit appellate court that the correct standard of review should have been whether the factual determination made by the agency was supported by substantial competent evidence. EDC, 107-108. This entire line of appellate proceedings was unchallenged, but this is the line of cases that are similar to the present situation in the Third District; where the appellate division of the circuit court departed from the essential requirements of law; applied the wrong case law; applied the wrong interpretation of the PIP statute; so the Third District granted the petition for certiorari and quashed the appellate court decision. Ivey, 283; EDC, 107-108.

The EDC case went back to the appellate circuit court, which this time found there was no substantial competent evidence to support the City denying the original petition and the Zoning Board of Appeals again filed a petition for writ of certiorari to the Fourth District, to reexamine the circuit court's decision and to remand the case back to the appellate circuit court again. EDC, 108. This time, however, the decision of the Fourth District was that it disagreed with the appellate circuit court's finding that there was no substantial evidence to support the City's zoning decision; and this Court quashed the Fourth District's decision for using the wrong standard of review.

This Court began by relying on City of Deerfield Beach v. Vaillant, 419 So. 2d 624 (Fla. 1982), which involved review of a civil service board administrative action and this Court pointed out that when the circuit appellate court reviews a decision of

an administrative agency, under Florida Rule of Appellate Procedure 9.030(c)(3), there are three components of review having to do with the administrative action. EDC, 108. First, there had to be a determination of whether procedural due process was accorded during the administrative action; second, whether the essential requirements of law were observed by the board of appeals; and whether the administrative findings and judgments were supported by competent substantial evidence. EDC, 108; citing, Vaillant at 626. This Court pointed out that when the circuit appellate court was reviewing the underlying decision it was not permitted to re-weigh the evidence, nor to substitute its judgment for that of the agency. EDC, 108. Again, this is the identical argument that Allstate made below, because the appellate circuit court had simply re-weighed the evidence, ruled on by the trial judge after the non-jury trial and substituted its fact finding for that of the trial judge.

This Court then noted that Vaillant had adopted the Fourth District Court of Appeal's rationale, that nobody should be entitled to three full repetitive reviews or appeals, and therefore, review in the district court of appeal, which would be the third plenary appeal is much narrower. This review has a two-part component; involving a determination of whether the circuit court in its appellate process, which was the second appeals proceeding, afforded procedural due process and applied the correct law; but if the district court of appeal simply disagreed with the circuit court's evaluation of the evidence, this would be improper review; and since this is what the Fourth

District did in round two of the EDC appeals, the decision was quashed. EDC, 108-109.

As clarified by this Court in Haines, the district court of appeal does not have to find both an absence of procedural due process and that incorrect principles of law were applied, it simply has to find one or the other and there was no question in this case that Allstate argued throughout that the circuit appellate court, the first appeal procedure in this case, had applied incorrect principles of law; which the Third District expressly held in its opinion in Ivey. Therefore, whether this Court looks to Haines, Nationwide, or EDC, the bottom line is the correct standard of review was applied by the Third District Court of Appeal; in granting the petition for writ of certiorari and in quashing the circuit appellate court decision, because it applied incorrect principles of law. Ivey, 283.

In summary, the Ivey Decision is in accord with all the case law cited by Ivey and there is no express and direct conflict, for this Court to resolve. Rather, the Petitioner is seeking a third appeal on the merits, using the same arguments repeatedly rejected below. This Court has no jurisdiction, nor any reason to review Ivey; the Petition must be denied and Ivey affirmed.

CONCLUSION

There is no express and direct conflict; the Ivey Decision is in accord with all Florida case law; and, this Honorable Court has no jurisdiction, nor any reason to review or reverse Ivey; and it must be affirmed.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was mailed this 16th day of November, 1999 to:

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