IN THE SUPREME COURT OF FLORIDA

CASE NO. 95,515

FARREN IVEY,

Petitioner,

-vs.-

ALLSTATE INSURANCE COMPANY,

Respondent.

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

PETITIONER'S INITIAL BRIEF ON THE MERITS

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CERTIFICATE OF TYPE SIZE AND STYLE

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STATEMENT OF THE CASE AND OF THE FACTS

This is a proceeding for discretionary review of the decision of the Third District Court of Appeal granting certiorari and quashing the Circuit Court's appellate decision in favor of the Plaintiff/Insured in a PIP case. R.191-95. In its decision quashed by the Third District on certiorari, the Dade Circuit Court Appellate Division had reversed the County Court's judgment in favor of the Defendant, Allstate. R.35.

The gist of the dispute between the parties at trial was whether Allstate's payment of some PIP benefits was untimely, because it was more than thirty days after the insurer was furnished with written notice of the fact of a covered loss and of the amount of same. R.36-37. Allstate's position was that it was excused from making timely payment of the full amount due by virtue of an ambiguity in the Plaintiff's treating physician's bill which Allstate failed to investigate before the lawsuit was filed. R.2.

The trial court entered judgment in favor of Allstate, and the Circuit Court Appellate Division reversed that judgment on appeal. R.35. In the order under review, the Third District quashed the Circuit Court's appellate decision, reinstating the trial court's decision in favor of Allstate. R.191.

On December 13, 1994, the Plaintiff, while a pedestrian, was struck by an automobile being operated by Allstate's insured, Enrique Arias. R.3. Plaintiff sustained injuries which resulted in medical treatment, and she made demand from Allstate for payment under Mr. Arias' PIP policy. R.3-4.

Plaintiff applied for PIP benefits by way of her attorney's letter to Allstate dated February 17, 1995, enclosing an Application for Benefits and the Attending Physician's Report. Tr.5[1]. The bills reflected treatments totaling $710.00 by Theodore R. Struhl, M.D. Tr.102-04. Of those charges, the sum of $385.00 was for electrical stimulation physiotherapy treatments. Tr.102-03.

Allstate wrote to Plaintiff's counsel on February 28, 1995, requesting execution of an affidavit by the Plaintiff before her claim could be considered. Tr.5. By letter dated March 15, 1995, Plaintiff's counsel provided Allstate with the Plaintiff's executed Affidavit for No Fault Benefits. Tr.6.

Allstate conducted absolutely no investigation into the reasonableness of the charges for Dr. Struhl's services, and did not so much as call the doctor to ask him about the bill. Tr.69.

[1]Citations to “Tr.” refer to the trial transcript included in the record at R.54-178, using the court reporter’s pagination.

Allstate did not review the medical records which would have reflected that Ms. Ivey had injured two parts of her body. R.36. Allstate did not timely pay 80% of Dr. Struhl's $710.00 bill ($568.00), but instead paid only $461.60. Tr.6. Only after Allstate rejected Plaintiff's request to pay the remainder of the 80% due, did Plaintiff then file the lawsuit below. Tr.6.

The underpayment of Plaintiff's claim resulted from Allstate's claimed misunderstanding about the number of electrical stimulation physiotherapy treatments which Ms. Ivey received from Dr. Struhl. Allstate interpreted the $385 portion of the medical bill submitted by Dr. Struhl to represent charges of $55 each for seven units of treatment (one unit on each of seven days of treatment). R.36. Instead, the $385 portion of the medical bill actually reflected fourteen units of electrical stimulation physiotherapy (conducted two per day on each of seven dates) at a charge of $27.50 each, or $55 per day. R.36.

The report which Dr. Struhl provided in addition to the Health Insurance Claim Form ("HICF")which Dr. Struhl submitted to Allstate (which was received in evidence below) "clearly stated that Ivey had two distinct injuries," in the words of the Circuit Court's appellate panel in this case. R.36. The Plaintiff was receiving treatment for injuries to her left lower leg and right shoulder.

Tr. 51. Each of the seven $55.00 daily charges represented two units of electrical stimulation physiotherapy; one to each of the injured areas Plaintiff's body, for a total of fourteen units of that form of treatment. Tr.16-17.

Allstate recognizes $36.00 as the reasonable and customary charge for one unit of electrical stimulation. Dr. Struhl's actual charge for each unit of electrical stimulation was only $27.50. Tr. 16-17. Therefore, Allstate should have paid a greater amount in PIP benefits than it actually paid due to its alleged misunderstanding.

At trial Plaintiff read from the deposition of Dr. Struhl that it was obvious to anyone knowledgeable about medicine and medical billing that his charges for electrical stimulation physiotherapy were to two parts of Plaintiff's body, putting Allstate on notice that each charge was for two modalities. Tr.42. However, without calling Dr. Struhl's office or asking for further information, Allstate mistakenly assumed that each of Dr. Struhl's seven $55.00 charges represented a single unit of electrical stimulation, so it only paid 80% of seven times its approved maximum of $36, for a total of $201.60 for that physiotherapy (plus 80% of the other charges, which are not at issue here, for a total paid of $461.60). Tr.21.

After more than thirty days passed from the time of Allstate's last request for information from Plaintiff (the affidavit), Plaintiff filed the action below seeking recovery of the unpaid medical benefits which should have been covered. R.36.

During the course of this lawsuit below, Allstate discovered its mistake in miscalculating the amount of medical payments which should have been paid under the policy, and remitted its check made payable to Dr. Struhl in the amount of $106.40. Tr.7. Allstate did not seek to settle Plaintiff's claim for attorney's fees, or otherwise obtain any agreement from Plaintiff prior to tendering the amount of principal it owed under the policy.

After its voluntary payment of the balance due for the medical treatment, there remained the issue of Plaintiff's entitlement to her attorney's fees and costs. Tr. 3. Allstate took the position at the trial of the fee entitlement issue that it was not liable because Dr. Struhl's bill did not clearly indicate that he had administered two units of electrical stimulation on each visit, rather than one unit. Tr. 19. Allstate took the position that it paid the bills within 30 days of taking Dr. Struhl's deposition and discovering that each $55 charge was for two units of electrical stimulation, and argued that it should not be liable for attorneys' fees under those circumstances. Tr. 24. Allstate's counsel argued

that "[i]n order for an attorney to be entitled to attorney's fees in PIP there has to be a wrongful withholding of benefits." Tr. 26.

Plaintiff sought entry of judgment in her favor on the ground that Allstate had failed to make payment of the amount of PIP benefits due within thirty days of being furnished with written notice of the fact of a covered loss and the amount of same. Tr. 8-9. Plaintiff's counsel cited numerous cases to the trial court which held that it was the insurer's burden to verify the amount claimed by an insured under the PIP statute within thirty days, and that Allstate had failed to do so in this case, entitling the Plaintiff to judgment. Tr. 10.

Plaintiff also argued that Allstate's voluntary payment of the balance due after suit was filed amounted to the functional equivalent of confession of judgment against it, entitling the Plaintiff to an award of fees under applicable authorities. Tr.7. Allstate did not condition that payment on Plaintiff's agreement to waive the claim for attorney's fees, but paid the amount due with full knowledge that Plaintiff was seeking a fee award too. Tr. 7.

The trial court accepted Allstate's arguments that the burden was on the Plaintiff to provide a PIP insurer with all of the information it needs to verify a claim. R. 37. On appeal before the

Circuit Court, Appellate Division, the County Court's judgment was reversed. R.38. The Circuit Court's appellate decision states as follows:

> On December 13, 1994, Ivey was struck by an automobile being operated by an Allstate insured motorist, while Ivey was walking on the sidewalk. She was injured in her lower left leg and right shoulder. Ivey timely applied for PIP benefits by attorney's letter dated February 17, 1995, which enclosed an application for benefits and the attending physician's report with a bill reflecting electrical stimulation treatments totaling $710.00. The invoice did not specify whether the treatments were for one or two injuries, however, the physician's report clearly stated that Ivey had two distinct injuries. On March 15, 1995, in response to a request by Allstate for additional information, Ivey provided the Health Insurance Claim Form (HICF).
>
> In April 1995 the doctor received payment from Allstate based upon the assumption that the doctor had only treated Ivey for one injury or modality. Allstate apparently only reviewed the bill and not the physician's report, and therefore, mistakenly 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. The doctor received a PIP payment reduced by [sic]80% from Allstate in the amount of $461.60, accompanied by an explanation of benefits from explaining how it arrived at the payment.
>
> Ivey filed a cause of action in May 1995 against Allstate for damages claiming that Allstate did not timely provide full payment for all treatments as required. Although all treatments were listed, the

doctor failed to itemized [sic] the bill detailing each treatment rendered.

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. It realized that the doctor was in fact owed the additional $106.00 requested by Ivey. Prior to November, 1995, Allstate did not review the other documents submitted, nor did they contact the doctor regarding an explanation of his charge(s). The doctor confirmed that the bill should have itemized the number of treatments given to the appellant, but that the information was clearly stated on his medical reports. Immediately thereafter, Allstate made a second payment in the amount of $106.40 which was the amount owed for the two modalities. The only issue remaining at trial was the award of attorneys' fees.

The trial court ruled that Allstate should be able to rely on the HICF submitted by Ivey to inform them of the cost of treatment. It further reasoned that the adjuster should not have to look beyond the HICF form, unless they were given notice of the error. The court, therefore, concluded that Allstate paid the amount owed the appellant within the statutory time period. This is so because they paid the balance within 30 days of learning of their mistake. The court also determined that, because Allstate paid within the statutorily required 30 days, there was no confession of judgment as argued by Ivey. Since the court held that there was no confession of judgment and there was timely payment, it also concluded that attorney's fees should not be awarded to Ivey's attorney. We do not agree with the trial court’s analysis.

R.36-37(footnotes deleted).

The Circuit Court reversed the judgment in Allstate's favor, holding that "[t]he case law is clear that the burden is on the insurer to 'investigate' and 'authenticate' a claim within 30 days of receiving notice of the claim." R.37. The Circuit Court held that Allstate would have learned that Dr. Struhl's bill was for two physiotherapy units each day "[i]f the Allstate adjuster had simply reviewed the medical bills and reports submitted by the doctor, or contacted the doctor's office." R.38.

The Circuit Court ruled that Plaintiff should recover her attorneys fees for trial and appeal based on the failure to timely pay the claim. R.38. That court found it "unnecessary to reach the confession of judgment issue." R.38.

Allstate then filed a Petition for Certiorari before the Third District Court of Appeal. R.1. That court granted certiorari review and quashed the Circuit Court's appellate decision. R.191. In a written opinion, the Third DCA stated, "We find that the Appellate Division of the Circuit Court departed from the essential elements of law," but qualified that finding with a footnote which stated as follows: "Given 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)." R.193 & n.2. The Third District did not address the confession of judgment argument, which was briefed as an alternative basis for affirmance.

Ivey filed a Motion for Rehearing, Motion for Certification, and Motion for Rehearing *En Banc. R.196. Those motions were based on the same three arguments here: 1) that the Circuit Court decision was correct; 2) that the voluntary payment was a confession of judgment; and 3) that the 3d DCA applied the incorrect standard of review on certiorari. R.196-207. Ivey's motions* were denied. R.227. This proceeding ensued. R.228.

SUMMARY OF THE ARGUMENT

The Third District's decision granting certiorari should be quashed under any of three analyses. First, the writ should not have issued because the Circuit Court appellate decision correctly held that Plaintiff was entitled to judgment against Allstate, as Allstate failed to pay all PIP benefits due within thirty days after it was furnished with written notice of the fact of the covered loss and the amount of same. Second, the Third District should have denied certiorari because the Circuit Court's appellate decision could have been sustained on the alternative ground that Allstate's voluntary payment of the claim after suit was filed was

the functional equivalent of a confession of judgment. Third, certiorari was inappropriate, because the Third District erroneously applied a simple error standard of review, impermissibly allowing two appeals rather than one.

The Third District Court of Appeal incorrectly quashed the Circuit Court's appellate decision, because the Circuit Court correctly held that Allstate impermissibly failed to make full payment of all payable PIP benefits within thirty days of being furnished with written notice of Plaintiff's claim. Under Florida law, the burden is on a PIP insurer to verify the amount claimed by the insured and to make payment of a covered loss within thirty days. That burden exists even if there is insufficient information initially furnished by the insured's treating physician along with the claim. Allstate failed to make any investigation or inquiry into the alleged ambiguity in Dr. Struhl's bill in this case. The medical information provided to Allstate reflected that Ms. Ivey was receiving treatment to two parts of her body, thereby placing Allstate on notice that the charges for treatment were for each part of her body. Allstate failed in its duty to verify and pay Plaintiff's claim within thirty days, and the Circuit Court correctly reversed the judgment of the County Court.

The Third District erroneously quashed the Circuit Court's decision, because the Circuit Court's decision also could properly have been based upon the ground that Allstate effectively confessed judgment when it made payment of the balance of Ms. Ivey's claim during the course of the litigation before the County Court. It is the law of Florida that where an insurer initially fails to pay a claim in a timely fashion, necessitating the filing of a lawsuit by the insured, the insurer is liable for the insured's attorney's fees by virtue of its voluntary payment during the course of litigation. Allstate's payment in the present case was not accompanied by any agreement between the parties to settle Plaintiff's fee claim, so the Circuit Court's decision could properly have rested upon this ground, and the writ of certiorari was improperly issued.

Finally, the Third District improperly applied an inapplicable standard of review in this case and readdressed the merit of the legal arguments being made by the parties. In reviewing the appellate decision of the Circuit Court, the district courts of appeal of Florida are not to simply engage in an analysis of whether the Circuit Court correctly applied the law. Instead, review is limited to a question of whether correct procedures were followed and the correct body of law was applied by the appellate

court. The Third District's approach to the present case effectively permitted two appeals in this matter, rather than the single appeal authorized under the law. Therefore, the Third District's decision should be quashed.

ARGUMENT

I.

THE CIRCUIT COURT APPELLATE DIVISION CORRECTLY REVERSED THE JUDGMENT FOR ALLSTATE BECAUSE ALLSTATE IMPERMISSIBLY FAILED TO MAKE FULL PAYMENT OF ALL PAYABLE PIP BENEFITS WITHIN THIRTY DAYS OF WRITTEN NOTICE OF THE FACT AND AMOUNT OF A COVERED LOSS

The Plaintiff was entitled to judgment in her favor in the action below because Allstate impermissibly failed to pay all of her PIP claim within the thirty-day period required under Florida law. Section 627.736(4), Fla. Stat. provides in pertinent part as follows: "Personal injury protection insurance benefits paid pursuant to this section shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same." Failure to pay PIP benefits when due entitles injured claimants to file suit for those benefits, and to recover their attorney's fees upon prevailing.

To start with, Allstate failed to pay any portion of the Plaintiff's claim within the original thirty-day period from the claim submitted on February 17, 1995. Thirty days thereafter, Plaintiff became entitled to attorney's fees and interest on the amount of her claim. Plaintiff did not then file suit, however,

but cooperated by providing Plaintiff's affidavit which Allstate requested.[2] Full payment of the covered portion of the medical bills still was not forthcoming.

It is no defense to Plaintiff's claim that Dr. Struhl's Health Insurance Claim Form ("HICF") was allegedly ambiguous concerning the number of electrical stimulation physiotherapy modalities received in his office.[3] There is nothing in the No-Fault Statute which permits tolling of the thirty-day period because the insurer lacks medical records which enable it to verify the claim; "the burden is on the insurer to authenticate the claim within thirty days." *Fortune Ins. Co. v. Pacheco*, 695 So. 2d 394, 395 (Fla. 3d DCA 1997).

Allstate defended at trial on the sole ground that it needed more information from Dr. Struhl about how many units of treatment his bills represented before it would make full payment of the

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[2]Plaintiff's counsel demonstrated reasonableness and restraint by not filing suit after that first thirty-day period had passed, and even stated at the fee entitlement hearing that this lawsuit was not brought to recover the nominal amount of the unpaid interest on the untimely part-payment of medical bills, but for the balance of the medical treatment rendered.

[3]Allstate had plenty of reason to know that Dr. Struhl performed fourteen units of electrical stimulation, rather than seven, or at least should have inquired further if the number of treatments was unclear. But it is not necessary for an insured to validate the amount of a PIP claim within thirty days; that burden is on the insurance company.

claim. There was not a hint of evidence (nor even any argument) that Dr. Struhl would not have provided that information within the original thirty-day period. He plainly would have given Allstate the information if Allstate had asked, because it would enable him to receive payment for his services in a timely fashion. But the law requires payment of attorney's fees to PIP claimants where the claim is not paid within thirty days, *even if the claimant's doctor fails to respond with additional information requested by the insurance company* within that time.

In a case involving the refusal of a doctor to cooperate with the insurance company's request for information about the Plaintiff's medical condition, the appellate court answered affirmatively the following question certified to be of great public importance: "WHETHER SECTION 627.736(4)(b), FLORIDA STATUTES REQUIRES A PIP INSURER TO PAY THE CLAIMED BENEFITS WITHIN THIRTY DAYS OF RECEIPT OF THE CLAIM RATHER THAN THIRTY DAYS OF RECEIPT OF MEDICAL VERIFICATION OF THE CLAIM." In *Martinez v. Fortune Ins. Co.*, 684 So. 2d 201 (Fla. 4th DCA 1996), the Court held that the refusal of the Plaintiff's doctor to provide within thirty days a disability report in support of the PIP claim did not act to extend the time for payment of the wage loss claim. It is not a question of how reasonable the insurer's request for

information may seem--as the request in *Martinez* was obviously reasonable--but a question of a statutory duty to pay, whether or not the insurer has received all the information it desires.

The insured does not bear the burden that the information requested will be delayed; the insurance company bears that burden. If no information is requested from the doctor in the first place (as none was requested here within thirty days), the insurance company should not avoid its responsibility for attorney's fees which it would have had to pay if the information had been requested, but not provided. Allstate did not within thirty days of the claim even ask the Plaintiff or Dr. Struhl for the information it claims it needed. *See* Tr.69. Allstate apparently just hoped that Plaintiff would be satisfied with the partial payment which it arbitrarily decided was enough, without any investigation whatsoever. That did not satisfy the PIP insurer's duty to its insured under Florida law.

Although unnecessary to support reversal here, Allstate had plenty of reason to know from Dr. Struhls' original billing and records that he had rendered fourteen units of electrical stimulation treatment, not just the seven Allstate paid. Dr. Struhl's narrative report dated February 5, 1995, was provided to the claims examiner who was assigned by Allstate to handle the

claim, Anna Rodriguez. Tr.71. That report indicates that Ms. Ivey was receiving physiotherapy treatments to both injured areas of her body, the left lower leg and the right shoulder. Tr.112-13.

Dr. Struhl's deposition testimony established that it was obvious to anyone knowledgeable about medicine and medical billing that his charges for electrical stimulation physiotherapy were to two parts of Plaintiff's body. Tr.42. Surely Allstate's vast experience as an issuer of motor vehicle policies qualified it as knowledgeable about medical billing.

The cases cited in Allstate's Third District petition for the proposition that an insurer cannot be liable for fees unless its conduct is wrongful do not apply to PIP cases, which are governed by a particular statute establishing a specific time deadline for payment of claims. *See New York Life Ins. Co. v. Shuster*, 373 So. 2d 916 (Fla. 1979)(not a PIP case, but a case brought on a life insurance policy claiming change of beneficiary was a forgery); *Manufacturer's Life Ins. v. Cave*, 295 So. 2d 103 (Fla. 1974)(life insurance policy not governed by a statute which required it to pay a claim within a set number of days; insurer paid the policy proceeds into the registry of the court when faced with conflicting claims thereto; *Equitable Life Assur. Society v. Nichols*, 84 So. 2d 500 (Fla. 1966)(disputed claim to life insurance proceeds, which

the insurance company deposited into the court in an interpleader action); *Ray v. Traveler's Ins. Co.*, 477 So. 2d 634 (Fla. 5th DCA 1985)(conflicting claims to life insurance proceeds). Those cases are not authority for the proposition that a PIP insurer is not liable when it fails to timely make payment under the applicable No-Fault statute.

Fortune Ins. Co. v. Iriban, 593 So. 2d 598 (Fla. 3d DCA 1992) does not set forth any facts involved in that case, but it cites two other authorities which indicates that the basis for the decision was the fact that no outstanding medical bills existed at the time the complaint was filed. *Iriban* cites as authority *Obando v. Fortune Ins. Co.*, 563 So. 2d 116 (Fla. 3d DCA 1990), which affirmed the denial of attorney's fees under a PIP policy because "[a]t the time the complaint was filed, *there were no unpaid medical bills pending* and the carrier had asked for follow-up information and any additional medical bills." (emphasis added). In the present case, however, there were unpaid medical bills pending at the time the Plaintiff's lawsuit was filed against Allstate.

Crotts v. Bankers and Shippers Ins. Co., 476 So. 2d 1357 (Fla. 2d DCA 1985), cited by Allstate below, does not support Allstate's position for two reasons. First, the case only involves "the

question of when an insurance company is obligated to pay attorney's fees under Section 627.428(1), Florida, Statutes (1983), *if it is faced with conflicting claims to the insurance policy proceeds." Id.* at 1358. (emphasis added). The case at bar has nothing to do with any conflicting claims to the policy proceeds, only a claim to the amount which Allstate eventually admitted it was liable for.

That case held that the insurance company was not liable for attorney's fees, again because there were conflicting claims to the policy proceeds, not because the insurer erroneously denied that it was liable to anyone for the benefits.

Another non-PIP case cited by Allstate below was *Government Employee Ins. Co. v. Battaglia*, 503 So. 2d 358 (Fla. 5th DCA 1987). In that case, *GEICO* had denied coverage under a policy of uninsured motorist benefits, not under a PIP policy governed by the thirty-day statutory deadline for payment. The court held that GEICO was not liable for attorney's fees because, at the time it denied coverage to the Plaintiff, there was no coverage to the Plaintiff. There was no coverage under the policy because a tortfeasor's liability insurer had admitted that there was coverage for the accident. The case did not involve a mere good faith denial of

coverage which existed, but a correct denial of coverage at the time the denial was made.

A rare PIP case cited below by Allstate was *Ledesma v. Banker's Ins. Co.*, 573 So. 2d 1042 (Fla. 3d DCA 1991). However, in *Ledesma*, the insurance company was not liable for the Plaintiff's attorney's fees "because the record clearly establishes that appellee paid the benefits due within thirty days of having been furnished with the bills and application for payment." *Id*. at 1043. In the present case, unlike *Ledesma*, Allstate did not make payment of the entire covered amount of Plaintiff's medical bills within thirty days of receiving those bills and Plaintiff's application for payment. Therefore, *Ledesma* is off-point and provides no authority for Allstate's position.

The burden was on Allstate in this case to verify the amount of coverage owed to Plaintiff within thirty days of being presented with the bills and Plaintiff's application for benefits. Allstate failed to take any action to verify the amount of coverage owed to Plaintiff, thereby obligating it to pay Plaintiff's attorney's fees in the action below.

There was nothing in the record to support the proposition that Plaintiff did not need treatment to both injured areas on each of the seven visits, for a total of fourteen units of treatment.

Allstate had ample notice that each charge was for two modalities. But if its argument is accepted that it could not tell from the billing how many such treatments were rendered, the burden under Florida law was on it to find out within thirty days, which it failed to do.

The Third District's reallocation to the insured of the burden to verify a PIP claim would threaten the constitutionality of the No-Fault Act. The intent of the no-fault statute is "to guarantee swift payment of PIP benefits." *Crooks v. State Farm Mutual Auto. Ins. Co.,* 659 So. 2d 1266, 1268 (Fla. 3d DCA 1995). The no-fault law was enacted to provide an alternative to litigation of the less serious claims resulting from motor vehicle accidents. Prior to the enactment of the no-fault law, claimants were entitled to sue in tort regardless of the amount of the claim or the insurance coverage of either party. The enactment of the no-fault statute provided for immunity from certain tort claims, and set up a system of insurance coverage regardless of fault for such claims. *Lasky v. State Farm Ins. Co.*, 296 So. 9 (Fla. 1974).

The law requires the owner of a motor vehicle to maintain security, by insurance or otherwise, for the payment of no-fault benefits. 296 So. 2d at 13. If the owner does not maintain the

required security, he is not entitled to immunity. 296 So. 2d at 14.

In exchange for the loss of the right to sue in tort, the accident victim received the right to "the *speedy* payment by his own insurer of medical costs, lost wages, etc. . . ." 296 So. 2d at 14 (emphasis added). While there were also other benefits conferred by the statute, it was this "prompt recovery of his major, salient out-of-pocket losses" that was the heart of the benefits conferred on the claimant. *Id.*

[T]he foundation of the legislative scheme is to provide *swift and virtually automatic payment* so that the injured insured may get on with his life without undue financial interruption. . . ." *Government Employees Ins. Co. v. Gonzalez*, 512 So. 2d 269, 270 (Fla. 3d DCA 1987)(emphasis added). As the Supreme Court recognized in *Industrial Fire & Casualty Ins. Co. v. Kwechin,* 447 So. 2d 1337, 1339 (Fla. 1983), central to its earlier decision in *Lasky* to uphold the no-fault law was the assurance that persons would in fact receive the "some economic aid in meeting their medical expenses and the like, in order not to drive them into dire financial circumstances. . . ."

Imposing on the insured the burden to clarify ambiguities in medical bills and to verify this amount would vitiate the

requirement that payment be “swift” and “virtually automatic.” It would place a severe obstacle in the way of an insured seeking prompt payment of a PIP claim. Indeed, many insureds would likely give up their valid PIP claims rather than face the risk of having to act as an interpreter of medical bills the insurer should understand itself, and to pay their own attorneys’ fees for the privilege.

The Circuit Court’s appellate decision was correct. The order under review should be quashed.

II.

PLAINTIFF WAS ENTITLED TO JUDGMENT IN HER FAVOR BECAUSE ALLSTATE CONFESSED JUDGMENT BY VOLUNTARILY PAYING THE BALANCE OF THE CLAIM AFTER SUIT WAS FILED

The Plaintiff was entitled to judgment in her favor and to recover her attorney's fees from Allstate because the voluntary payment of a claim by an insurer after suit has been filed "is the functional equivalent of a confession of judgment or a verdict in favor of the insured." *Wollard v. Lloyd's and Companies of Lloyd's*, 439 So. 2d 217, 218 (Fla. 1983).

Where a PIP carrier initially fails to pay a claim in a timely fashion, then voluntarily pays it after suit is filed, it is liable

for the claimant's attorney's fees, regardless of the insurer's good faith in initially defending the lawsuit. *See United Auto Ins. Co. v. Zulma*, 661 So. 2d 947 (Fla. 4th DCA 1995). Therefore, even if this Court otherwise would be inclined to accept Allstate's argument that its alleged good faith immunized it from Plaintiff's claim for attorney's fees, the merits of that argument were abandoned by Allstate's voluntary payment of the full amount of Plaintiff's covered claim, and cannot be revisited.

The legal principle underlying this Court's holding in *Wollard* and cases following it is critical to fulfilling the purpose of the attorneys fee statutes applicable to insurance cases. If insurance companies could insulate themselves from liability for fees by paying claims voluntarily, it would foster greater resistance to paying valid claims before suit was filed. Insurers would have everything to gain and nothing to lose by denying claims and forcing suit to be filed. Some valid claims would never be pursued to litigation if insurers were allowed to pay just the benefits due without paying the insured's fees as well.

The Third DCA should have denied certiorari on the ground that this confession of judgment issue provided an alternative basis in the record to uphold the Circuit Court's decision. *See Applegate v.*

Barnett Bank, 377 So. 2d 1150 (Fla. 1979). This Court should quash the order under review.

III.

THE THIRD DCA ERRONEOUSLY APPLIED AN IMPERMISSIBLE STANDARD OF REVIEW UPON CERTIORARI

The district courts of appeal in reviewing an appellate decision of the Circuit Court are not permitted to simply engage in an analysis of whether the Circuit Court correctly applied the law. Instead, the scope of review is whether correct procedures were followed and the correct body of law was applied by the appellate court. If the district courts were to review the substance of the Circuit Court's appellate decision the parties would, in essence, have two appeals of the trial court's judgment, instead of just the one the law permits.

This Court has stated the standard of review in cases such as this one as follows:

> [T]he standard of review to guide the district court when it reviews the circuit court's order under Florida Rule of Appellate Procedure 9.030(b) (2)(B) . . . has only *two* discrete components.
>
> "The district court, upon review of the circuit court's judgment, then determines [1] whether the circuit

> court afforded procedural due process and [2] applied the correct law."

Education Development Center, Inc. v. City of West Palm Beach Zoning Board of Appeals, 541 So. 2d 106, 107 (Fla. 1989) (emphasis in original). There was no contention raised in the Petition for Certiorari filed by Allstate that the Circuit Court did not follow procedural due process requirements. The Circuit Court followed all direct appellate procedures, permitting the parties to file briefs and motions, and to engage in oral argument.

Likewise, the opinion of the Circuit Court reflects that it applied the correct body of law: the cases applicable to a PIP claim in which the insurance company fails to pay the amount due within the statutory period. Therefore, the Third District should not have engaged in an analysis of whether the Circuit Court's result was substantively correct, and the Petition for Certiorari should have been denied or dismissed.

The last word from this Court on the scope of review issue is contained in *Haines City Community Development v. Heggs*, 658 So. 2d 523 (Fla. 1995). The Court in that decision analyzes both *Combs v. State*, 436 So. 2d 93 (Fla. 1983) and *Education Development Center*, noting that "both decisions mandate a narrow standard of review and emphasize that certiorari should not be utilized to provide 'a second appeal.'" *Id*. at 529. The Court in *Haines City* reaffirmed

the standard of review which forbids district courts of appeal from substituting their judgment for that of the appellate division of the Circuit Court, so long as the correct body of law has been applied and procedural due process has been observed.

"It is well-established that certiorari should not be used as a vehicle for a second appeal in a typical case tried in county court." *Stilson v. Allstate Ins. Co.,* 692 So. 2d 979, 982 (Fla. 2d DCA 1997). As held by the Second District in *Stilson,* which was a PIP case, this Court's decisions in *Combs and Heggs* do not support the exercise of certiorari jurisdiction where the Circuit Court appellate division simply misapplies PIP law.[4]

The Third District here paid lip service to the applicable standard by stating that it found a departure from the "essential requirements of law." R.193. However, the Third District quickly qualified its finding meeting that standard by quoting from a case granting certiorari based only on an "erroneous interpretation of this [PIP] law." *Id.* n.3. In other words, the Third District considered that a mere erroneous interpretation of PIP law amounts to a departure from the "essential elements of law" sufficient to

[4] Ivey does not agree that the Circuit Court misapplied PIP law, but if it did that error would not support certiorari.

warrant certiorari. That would open the door to two appeals in every PIP case.

The Third District employed an incorrect standard to review the appellate decision of the Circuit Court. Therefore, the petition should have been denied or dismissed, and the decision granting certiorari should be quashed.

CONCLUSION

The Third District's decision should be quashed under any of three analyses. Allstate impermissibly failed to make full payment of PIP benefits due within thirty days of notice of the loss; Allstate effectively confessed judgment by voluntarily paying the claim after suit was filed; and the Third DCA erroneously applied an impermissible standard of review in granting certiorari.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that true copies hereof were served by United States mail, upon Frank S. Goldstein, Green, Murphy, Wilke & Murphy, P.A., Suite 200, 633 South Andrews Avenue, Ft. Lauderdale, Florida 33301 and Richard A. Sherman, Richard A. Sherman, P.A., 1777 South Andrews Avenue, Suite 302, Ft. Lauderdale, Florida 33316, on this, the 12th day of October, 1999.

_____
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