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In the Florida Supreme Court

MRI ASSOCIATES OF TAMPA, INC., d.b.a. Park Place MRI,

Petitioner,

vs. **Fla. S. Ct. Case No. SC18-1390**

STATE FARM MUTUAL AUTO. INS. CO., Fla. 2d DCA Case No. 2D16-4036

Respondent.

_____/

DISCRETIONARY REVIEW OF A DECISION OF THE FLORIDA SECOND DISTRICT COURT OF APPEAL

PETITIONER'S AMENDED INITIAL BRIEF ON THE MERITS

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STATEMENT OF THE CASE AND FACTS

This case involves the statutory methods described in section 627.736, Florida Statutes (2012-2019)[1] for calculating personal injury protection ("**PIP**") insurance benefits for medical bills. Section 627.736 (the "**PIP statute**") has a "reasonable medical expenses coverage mandate," which requires motor vehicle insurers to pay 80% of reasonable medical expenses, up to $10,000. *See* § 627.736(1)(a). There is only one such mandate, but "there *are* two different methodologies" for satisfying that mandate. *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*, 141 So.3d 147, 156 (Fla. 2013) ("***Virtual III***") (emph. in original); *Allstate Ins. Co. v. Orthopedic Specialists*, 212 So.3d 973, 976 (Fla. 2017) (emph. added).

The first method determines the reasonable amount of benefits using a fact-dependent method, was originally adopted in 1971, and is currently described in section 627.736(5)(a). The second "alternative" and "permissive" method is a "reimbursement limitation" that is based on a fixed and predetermined "schedule of maximum charges" and numerous other terms and conditions that was originally adopted in 2008, and is currently described in section 627.736(5)(a)1-5. *See, Virtual III,* at 156 (2008 amendments to PIP statute "provided an alternative, permissive way" to satisfy the reasonable medical expenses coverage mandate); *Progressive*

[1] Unless otherwise indicated, citations herein to section 627.736 refer to the 2012 through 2019 versions of that statute, in effect since July 1, 2012.

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Select Ins. Co. v. Florida Hospital Medical Center, 260 So.3d 219, 220-226 (Fla. 2018) (describing the second method as "the reimbursement limitation").

In 2012, this Court held in *Virtual III,* that "[t]he 2008 fee schedule amendments used the word 'may' to describe an insurer's ability to limit reimbursements" based on the fee schedule method, which was, therefore, "clearly permissive and offered insurers ***a choice*** in dealing with their insureds as to whether to limit reimbursements based on the Medicare fee schedules ***or*** whether to continue to determine the reasonableness of provider charges for necessary medical services rendered to a PIP insured based on the factors enumerated in [former] section 627.736(5)(a)1 [now (5)(a)]." *Virtual III,* 141 So.3d at 156-157 (emph. added). Because the PIP statute affords insurers two different methods for calculating reimbursements, this Court held "the insurer must clearly and unambiguously elect the permissive payment methodology in order to rely on it." *Id.* at 158. Another important premise of this election requirement is that the two methods are "mutually exclusive." *Id.,* 141 So.3d at 160 (Canady, J., dissenting).

The permissive and mutually exclusive nature of the fee schedule method remains to this day. The 2008-2011 version of section 627.736(5)(a) stated that "[t]he insurer ***may*** limit reimbursement to 80 percent of the following schedule of maximum charges...." (Emph. added). In 2012, that subsection was renumbered to (5)(a)1, but it still says the same thing.

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In 2017, this Court (in a decision authored by Chief Justice Canady) followed this same election requirement. *Orthopedic,* 212 So.3d at 976-977. Most recently, in 2018, this Court (in a decision authored by Chief Justice Canady) unanimously held the fee schedule method does not apply to medical expenses which the insured alone is obligated to pay and which are not recoverable as PIP benefits under the insurance policy, such as the insured's deductible. *See Florida Hospital*, 260 So.3d at 224.

In this case, the Respondent, State Farm Mutual Automobile Insurance Company ("**State Farm**"), filed a declaratory action involving 19 PIP claims, and sought a determination that its insurance policy ("**Policy Form 9810A**") lawfully elects the fee schedule method (R 8-116).[2] The Petitioner, MRI Associates of Tampa, Inc., doing business as Park Place MRI (the "**Health Care Provider**") filed a counterclaim alleging that Policy Form 9810A combines the two methods into an unlawful "hybrid" method, and that State Farm also unlawfully relies on the "limiting charge" fee schedule when calculating benefits (R 117-151, 176-197).

The parties filed competing summary judgment motions and stipulated to the material facts (R 207-212, 453-524, 683-826, 840-882, 910-939). The trial court entered a final declaratory judgment, which in pertinent part, ruled:

> … State Farm has failed to clearly and unambiguously elect the Medicare Fee Schedule Method in Policy Form 9810A, and has instead

[2] Citations to **"R"** refer to the original record on appeal of the trial court proceedings. Citations to **"RII"** refer to the record of the appellate proceedings in the Second District.

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> adopted an unauthorized hybrid method comprised of elements from both the Medicare Fee Schedule Method described in Section 627.736(5)(a)1-5, Florida Statutes (2012-2015) and the fact dependent Reasonable Amount Method described in Section 627.736(5)(a), Florida Statutes (2012-2015).
>
> … As a result, State Farm is required to pay [the Health Care Provider's] PIP claims at issue in this case in accordance with the Reasonable Amount Method by default, instead of the unauthorized hybrid method described in Policy Form 9810A or the Medicare Fee Schedule Method, and State Farm is not authorized to rely on Medicare's limiting charge fee schedule.

(R 1165-1166).

State Farm appealed to the Florida Second District Court of Appeal (R 1167-1173), and that court reversed in *State Farm Mut. Auto. Ins. Co. v. MRI Associates of Tampa, Inc.*, 252 So.3d 773 (Fla. 2d DCA 2018). Despite acknowledging the need for an "election" in the insurance policy and conceding that State Farm's policy adopts both methods, the Second District held (based on the 2012 amendments which renumbered various subparagraphs of the PIP statute) that *Virtual III* and *Orthopedic* do not apply to Policy Form 9810A, that "there are no longer two mutually exclusive methodologies," and that as a result, a PIP insurer "may not disclaim the fact-dependent calculation of reasonable charges" but "may elect to limit its payment in accordance with the schedule of maximum charges." *See MRI Associates,* 252 So.3d at 777-778. Thus, the Second District concluded that a PIP insurer must always adopt the fact-dependent method in its insurance policy but may (at the same time) also rely on the fee schedule method.

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In reversing, the Second District certified the following question to this Court:

> DOES THE 2013 PIP STATUTE AS AMENDED PERMIT AN INSURER TO CONDUCT A FACT-DEPENDENT CALCULATION OF REASONABLE CHARGES UNDER SECTION 627.736(5)(a) WHILE ALLOWING THE INSURER TO LIMIT ITS PAYMENT IN ACCORDANCE WITH THE SCHEDULE OF MAXIMUM CHARGES UNDER SECTION 627.736(5)(a)(l)?

MRI Associates, 252 So.3d at 779.

The Health Care Provider moved for rehearing (RII 1185-1211), and the Second District denied that motion (RII 1230). This timely appeal followed (RII 1230). By order dated July 17, 2019, this Court accepted jurisdiction.

SUMMARY OF THE ARGUMENTS

The Second District's opinion reached the wrong result to the detriment of thousands of State Farm insureds and their health care providers, and to the financial windfall of State Farm. The Legislature's purpose for adopting the "alternative" and "permissive" fee schedule method in 2008 was to put an end to costly PIP litigation over the issue of whether a medical charge is reasonable. The Second District's erroneous decision will return PIP litigation to the pre-2008 situation and confuse medical billing and collection practices concerning the unpaid balances of medical bills. Accordingly, this Court should answer the certified question in the negative, reverse the Second District, and affirm the trial court.

STANDARD OF REVIEW

Because this Court is being called upon to engage in the legal interpretation

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of the PIP statute and the insurance policy, this appeal is governed by the *de novo* standard of review. *See Virtual III,* 141 So.3d at 152; *Orthopedic,* 177 So.3d at 975; *Florida Hospital*, 260 So.2d at 223.

ARGUMENTS

THE SECOND DISTRICT ERRONEOUSLY CONCLUDED THAT THE PIP STATUTE, AS AMENDED IN 2012, PERMITS AN INSURER TO CONDUCT A FACT-DEPENDENT CALCULATION OF REASONABLE CHARGES UNDER SECTION 627.736(5)(a) WHILE ALLOWING THE INSURER TO LIMIT ITS PAYMENT BASED ON THE SCHEDULE OF MAXIMUM CHARGES UNDER SECTION 627.736(5)(a)1

(a) Introduction

Since 1971, the PIP statute has identified a fact-dependent method for determining the reasonable price that could be collected from a PIP insurer. §627.736(5)(a), Fla. Stat. (1971). However, that fact-dependent method often led to prolonged and costly litigation against insurers (like State Farm) who chose to "go to the mat" over each medical bill. *See, e.g., State Farm Fire & Cas. Co. v. Palma,* 555 So.2d 836, 837 (Fla. 1990). While, in isolation, medical providers appear to be short-changed by small amounts, the cumulative effect of the PIP insurers' underpayments is that they reap millions in unlawful windfall profits. "An insurance company can make a lot of money on the small claims … because if you save a few dollars on a huge number of claims, it's worth more than saving a lot of dollars on a very small number of claims." M. Reilly, "Insurance Claim Delays Deliver Massive

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Profits to Industry by Shorting Customers," *Huffington Post* (Dec. 13, 2011) (*www.huffingtonpost.com/2011/12/13/insurance-claim-delays-industry-profits-allstate-mckinsey-company_n_1139102.html*).

In 2008, a "permissive" second method was adopted as an "alternative" that permitted (but did not require) insurers to "elect" in their policies to pay *reduced* rates based on a set of fixed and predetermined fee schedules,[3] in order to avoid litigating the issue of reasonableness. *See Florida Motor Vehicle No-Fault Law*, Report No. 2006-102, p. 96-97 (Fla. Sen. Comm. on Banking & Fin. Nov. 2005) ("fee schedule would ... reduce litigation over the reasonableness of medical fees") (http://archive.flsenate.gov/data/Publications/2006/Senate/reports/interim_reports/pdf/2006-102bilong.pdf); *Virtual II*, 90 So.3d at 323 (the 2008 fee schedule amendments to the PIP statute "sought to address the enormous costs and inefficiencies of the law prior to amendment"). But the fee schedule method has, instead, triggered thousands of lawsuits (including class actions) and appeals in Florida's state and federal courts. Now, eleven years later, the issue of how and when a PIP insurer is allowed to apply the fee schedules is still hotly litigated in Florida.

The two different methods have different consequences for the insured and

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[3] The fee schedule method pays much lower benefits than the fact-dependent method. *See Geico Gen. Ins. Co. v. Virtual Imaging Servs.*, Inc., 90 So.3d 321, 323 (Fla. 3d DCA 2012) ("***Virtual II***"); *Orthopedic*, 212 So.3d at 982 (Pariente, J., dissenting), *citing Geico Indem. Co. v. Phys. Grp., LLC*, 47 So.3d 354, 356 (Fla. 2d DCA 2010); *Allstate v. Stand–Up MRI*, 188 So.3d 1, 3 (Fla. 1st DCA 2015).

the medical provider. For example, the PIP statute prohibits medical providers from balance-billing insured patients for amounts lawfully paid using the fee schedule method, but not amounts paid under the fact-dependent method. *See,* §627.736(5)(a)4, Fla. Stat. If PIP insurers are allowed to use either or both methods and to pick-and-choose among the elements of both, then insured patients, their medical providers, and the Courts cannot know how much the insurer must pay, how much the insured patient must pay, and how much the medical provider can collect from the insurer and from the insured patient. Combining the two methods returns PIP to the pre-2008 era of litigating over the reasonable amount of medical charges—the very situation that the Legislature adopted the fee schedules to avoid.

(b) State Farm's insurance policy combines the two methods

Citing section 627.736(5)(a)5, the Second District acknowledged the PIP insurer must make an "election" by "provid[ing] notice to the insured in the policy." *MRI Associates*, 252 So.3d at 776. Nonetheless, the Second District also concluded State Farm's insurance policy could lawfully combine the two methods based on the 2012 amendments that renumbered the subparagraphs of section 627.736(5)(a)1-5. *See MRI Associates*, 252 So.3d at 777-778.

Setting aside, for the moment, the Second District's legal conclusion that the two methods can be combined, there can be no reasonable factual dispute that State Farm's insurance policy does combine the two methods. Indeed, the Second District

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found that the policy "tracks" both methods. *MRI Associates*, 252 So.3d at 775. In pertinent part, Policy Form 9810A defines the terms "medical expenses" and "reasonable charge," as follows:

> *Medical Expenses* means *reasonable charges* incurred for medically necessary, surgical, X-ray, dental, and rehabilitative services . . . . .
>
> . . . . .
>
> *Reasonable Charge,* which includes reasonable expense, means an amount determined by *us* to be reasonable in accordance with the *No-Fault Act,* considering one or more of the following:
> 1. usual and customary charges;
> 2. payments accepted by the provider;
> 3. reimbursement levels in the community;
> 4. various federal and state medical fee schedules applicable to *motor vehicle* and other insurance coverages;
> 5. the schedule of maximum charges in the *No-Fault Act,*
> 6. other information relevant to the reasonableness of the charge for the service, treatment, or supply; or
> 7. Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, if the coding policy or payment methodology does not constitute a utilization limit.

(R 220-221; underline added; italics original).

This "reasonable charge" definition combines elements of both methods. Specifically, paragraphs 1, 2, 3, 4, and 6 correspond to elements of the fact-dependent method listed in section 627.736(5)(a). In contrast, paragraphs 5 and 7 correspond to elements of the fee schedule method found in (5)(a)1 and 3.

The issue for this Court to decide is whether the 2012 amendments to the PIP statute were intended to permit PIP insurers to combine what were previously two mutually exclusive methods into a single hybrid method. As explained herein, the

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2012 amendments do not authorize the two methods to be combined, and the consequences of such a combination undermines the Legislature's purpose for enacting the alternative fee schedule method in 2008 and will cause confusion and litigation concerning medical billing and collection practices.

(c) The Legislature's renumbering of the subparagraphs of Section 627.736(5)(a)1-5 in 2012 was not a substantive change and did not overturn prior appellate decisions

In its decision, the Second District concluded that in 2012, the Legislature "substantially amended section 627.736(5)" by renumbering its subparagraphs. *MRI Associates*, 252 So.3d at 777-778. The Second District concluded that because the Legislature renumbered the subparagraphs, "there are no longer two mutually exclusive methodologies," and that a PIP insurer "may not disclaim the fact-dependent calculation of reasonable charges" but "may elect to limit its payment in accordance with the schedule of maximum charges." *Id.*

The Second District's conclusion is incorrect. The permissive nature of the "alternative" fee schedule method in effect during 2008-2011 was not changed by the 2012 amendments. Moreover, none of the parties had ever argued or presented the issue of whether the renumbering of the subparagraphs changed the meaning of the statutory language. The issue appeared for the first time in the Second District's opinion, even though the Second District did not raise any questions about it at oral argument and did not request the parties to brief it. Thus, this issue and the Second

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District's holdings derived from it were not preserved for appeal and were beyond the scope of the Second District's appellate review. *See Manatee County School Board v. NationsRent, Inc.*, 989 So.2d 23, 25 (Fla. 2d DCA 2008) (it is "inappropriate" for appellate court to depart from role of neutral tribunal and develop arguments that have not been presented; appellate court should "work within the framework of the briefs").

It is inappropriate to raise an issue for the first time on appeal, and an appellate court will not consider arguments not presented to the trial judge. *Dober v. Worrell*, 401 So.2d 1322, 1323-24 (Fla.1981). To preserve an argument for appeal, that argument must first be presented to the trial judge. *See, e.g., City of Orlando v. Birmingham,* 539 So.2d 1133, 1134-35 (Fla. 1989). Moreover, appellate review is limited to the same specific grounds raised in the trial court. *See e.g., Chamberlain v. State*, 881 So.2d 1087, 1100 (Fla. 2004); *W.R. Grace & Co.-Conn. v. Dougherty*, 636 So.2d 746, 749 (Fla. 2d DCA 1994). Because the Second District's renumbering argument and the holdings derived from it were never raised by State Farm, these issues were waived and could not serve as a lawful basis for the Second District to reverse the trial court's judgment, effectively offering an advisory opinion on issues never raised or briefed by the parties.

More importantly, besides being unpreserved and waived, the Second District's renumbering analysis is also incorrect. In 2012, the Legislature did

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renumber the subparagraphs within (5)(a)1-5 of Section 627.736. However, that renumbering was merely editorial in nature and does not support the Second District's conclusion "that there are no longer two mutually exclusive methodologies[.]" *MRI Associates*, 252 So.3d at 778.

First, the permissive nature of the fee schedule method described in the 2008-2011 version of (5)(a) remains unchanged in the 2012-2019 version of section (5)(a)1. Former (5)(a) stated that "[t]he insurer ***may*** limit reimbursement to 80 percent of the following schedule of maximum charges" and the current (5)(a)1 still says the exact same thing. In *Virtual III,* this Court found the use of the word "may" in former (5)(a) was "clearly permissive" and gave insurers a "choice" to limit reimbursements based on the fee schedule method "or" to continue using the fact-dependent method. *Virtual III,* 141 So.3d at 156-157. Based on the permissive nature of the new fee schedule method, this Court held "the insurer must clearly and unambiguously elect the permissive payment methodology in order to rely on it." *Id.* at 158. Despite being renumbered from (5)(a) to (5)(a)1, the statutory permissive language which led this Court to require PIP insurers to clearly and unambiguously "elect" the fee schedule method remains intact and unchanged.

This leads us to the question of why the Legislature renumbered the subparagraphs. In the 2008-2011 versions of the PIP statute, the fact-dependent method was described in subparagraph (5)(a)1, and the fee schedule method was

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described in subparagraphs (5)(a)2-5. During that time period, the PIP statute did not have a subsection "(5)(a)." Instead, the statute skipped from subsection (5) directly to (5)(a)1, without a subsection (5)(a) in between. This is an improper outline structure that the Legislature seeks to avoid. *See Guidelines for Drafting Legislation*, Fla. House of Rep. House Bill Drafting Service (2014), p. 91 ("Subdividing a section") (*https://bit.ly/2spna7l*). The 2012 amendments fixed that problem by renumbering the subsections to insert the missing "(5)(a)" but that did not change the meaning or effect of the pre-existing statutory language, and the Legislature expressed no intention to change the meaning.

Before subparagraphs (5)(a)1-5 were renumbered in 2012, Florida appellate courts uniformly held that the 2008 statutory language presented two distinct payment methods and required an insurer to choose one or the other. *See Kingsway Amigo Ins. Co. v. Ocean Health, Inc.*, 63 So.3d 63 (Fla. 4th DCA 2011); *DCI MRI, Inc. v. Geico Indem. Co.*, 79 So.3d 840 (Fla. 4th DCA 2012); *Geico Indem. Co. v. Virtual Imaging Servs., Inc.*, 79 So.3d 55 (Fla. 3d DCA 2011) ("***Virtual I***"); *Virtual II*, 90 So.3d 321. *See also*, *Nationwide Mut. Fire Ins. Co. v. AFO Imaging, Inc.*, 71 So.3d 134, 137-138 (Fla. 2d DCA 2011) (fee schedule method is "utilized in *computing the* ***minimum*** amount" payable by PIP insurance) (emph. added).

In *Kingsway*, the Fourth District held that the PIP statute "allows an insurer to <u>choose</u> <u>between</u> two different payment calculation methodology options" and

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"anticipates that an insurer will make a choice" which must be "clearly and unambiguously" elected. *Id.,* 63 So.3d at 67-68 (emph. added). Thereafter, in *DCI MRI*, the Fourth DCA explained that *Kingsway* required PIP insurers to provide adequate "notice" to insureds and health care providers of the intent to adopt the fee schedule method. *Id.,* 79 So.3d at 842.

In 2012, the Legislature adopted some amendments to the PIP statute, which included the renumbering of (5)(a) and its subparagraphs. However, those amendments did not alter the permissive and mutually exclusive nature of the fee schedule method. In pertinent part, the amendments were as follows:

> (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
>
> (a)~~1.~~ 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 the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. ~~In no event,~~ However, ~~may~~ such a charge may not exceed ~~be in excess of~~ the amount the person or institution customarily charges for like services or supplies. In determining ~~With respect to a determination of~~ whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle ~~automobile~~ and other

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insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

1.~~2.~~ The insurer ***may*** limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002(9) provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under:

(I) The participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

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However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2.~~3.~~ For purposes of subparagraph 1. ~~2.~~, the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which ~~at the time~~ the services, supplies, or care is ~~was~~ rendered and for the area in which such services, supplies, or care is ~~were~~ rendered, and the applicable fee schedule or payment limitation applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable ~~participating physicians~~ schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

3.~~4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. ~~2.~~ must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is ~~would be~~ entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

4.~~5.~~ If an insurer limits payment as authorized by subparagraph 1. ~~2.~~, the person providing such services, supplies, or care may not bill

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> or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.
>
> 5. Effective July 1, 2012, an insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

See ch. 2012-197, Laws of Fla. (2012) (underlines and strike-through in original; bold and italics added).

The Legislature "is presumed to know the judicial constructions of a law when enacting a new version of that law" and "is presumed to have adopted prior judicial constructions of a law unless a contrary intention is expressed in the new version." *Essex Ins. Co. v. Zota*, 985 So.3d 1036, 1043 (Fla. 2008); *Brannon v. Tampa Tribune,* 711 So. 2d 97, 100 (Fla. 1st DCA 1998). Here, there is nothing in the 2012 amendments to Section 627.736(5)(a)1-5 or any of the legislative history to rebut that presumption. Nothing in the statute or the legislative history manifests any intent to legislatively overturn the appellate decisions concerning the fee schedule method that were previously issued by the district courts of appeal, such as *Nationwide, Kingsway, DCI MRI, Virtual I,* and *Virtual II. Compare Barns v. State*, 768 So.2d 529, 532 (Fla. 4th DCA 2000) (reference in legislative history to a conflict between

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specific district court decisions suggested that primary motivation of statute was to legislatively overturn appellate decision).

The 2012 amendments did not alter any of the operative language in the 2008-2011 version of the PIP statute that led this Court to hold (like the district courts had previously held) that "there *are* two different methodologies." *Virtual III*, at 156; *Orthopedic*, at 976. As renumbered in 2012, the fact-dependent method is still worded the same as it was before, but it is now described in subparagraph (5)(a) instead of (5)(a)1, and certain internal elements of the fee schedule method were slightly amended and are described in subparagraphs (5)(a)1-5, instead of (5)(a)2-5. Besides the renumbering, some additional Medicare fee schedules were added to the current (5)(a)1.f, the time periods covered by the respective Medicare fee schedules were identified in the current (5)(a)2, a third sentence was added to the current (5)(a)3, and a new (5)(a)5 was added. Notably, however, none of the operative 2008-2011 language which distinguished between and confirmed the distinct and alternative nature of the two methods was altered in the 2012 amendments, and there is no legislative history indicating that the Legislature intended to combine the two methods. To the contrary, the plain language of the 2012 amendments confirms that there are still two distinct and alternative methods.

The same words in the 2008-2011 version of Section 627.736(5)(a)1-5 that signified the existence of two different methods still remain in the 2012 amended

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version of Section 627.736(5)(a)1-4. For example, the changes to former (5)(a)1 which are now in the current (5)(a) are strictly editorial and grammatical in nature, and do not change the meaning of the original language describing the fact-dependent method.

Current (5)(a)1-4 include what was formerly (5)(a)2-5 and still describe the separate permissive fee schedule method. Just like the former (5)(a)2, the current (5)(a)1 still states, "The insurer ***may*** limit reimbursement to 80 percent of the following schedule of maximum charges…." (Emph. added). The cross-references in current (5)(a)2-5 back to current (5)(a)1 make it clear that all of these provisions apply only to the fee schedule method. Had the Legislature intended to combine the two methods, it would not have limited the applicability of (5)(a)2-5 to situations that exclusively involve (5)(a)1.

Under both former (5)(a)3 and current (5)(a)2, the PIP insurer who elects the Medicare Part B fee schedules cannot pay less than the corresponding fee schedules would have paid in 2007. Had the Legislature intended to combine the two methods, there would be no purpose for this provision which establishes the minimum amount payable under the fee schedule method for services described in Medicare Part B.

Under both former (5)(a)5 and current (5)(a)4, when a PIP insurer limits payment as authorized by the fee schedule method, a health care provider is prohibited from balance billing the insured patient "except for amounts that are not

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covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits." This balance-billing prohibition does not apply to medical expenses paid under the fact-dependent method or medical expenses not covered by PIP. Consistent with this subsection, this Court recently held (in a unanimous decision) that the fee schedule method does not apply to medical expenses which the insured alone is obligated to pay and which are not recoverable as PIP benefits under the insurance policy, such as medical expenses covered by the insured's deductible. *Florida Hospital,* 260 So.3d at 224. As such, the *Florida Hospital* decision inherently recognized that the 2012 amendments did not alter the distinct nature of the two methods. If, as the Second District concluded, the 2012 amendments combined the two methods into a single new method, that situation undermines that premise of *Florida Hospital*.

Last, but not least, the 2012 amendments adopted a new (5)(a)5, which states that PIP insurers may "only" limit payment under (5)(a)1 if the insurance policy includes "a notice" at the time of issuance or renewal that the insurer intends to do so "pursuant to" the schedule of maximum charges. This requirement (which codified prior case law and expressly required a distinct notice) only applies to the fee schedule method. Such "a notice" is not required if the PIP insurer intends to continue using the longstanding fact-dependent method described only in (5)(a). The new (5)(a)5 also provides an exception to the rule announced in *Nationwide* that the

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fee schedule method sets the minimum reimbursement. That exception permits a PIP insurer to pay less than the fee schedule amount only when "a provider submits a charge for an amount less than the amount allowed under" the schedule of maximum charges. If the Legislature had intended to combine the two methods into one, there would be no reason for subsection (5)(a)5 to require PIP insurers to provide such "a notice" and no reason to create an exception for medical bills that are less than the minimum amount payable under the fee schedules.

In summary, as renumbered in 2012, none of the amendments suggest that the Legislature intended to combine the two methods. Instead, the plain language of the 2012 amendments confirms that the various terms and conditions set forth in the renumbered (5)(a)2-5 only apply to the schedule of maximum charges listed in (5)(a)1. None of the terms and conditions set forth in the renumbered (5)(a)1-5 apply to the different fact-dependent method described in the renumbered (5)(a). And, if the two methods were being combined, there would be no reason for the new (5)(a)5 to require the PIP insurer to provide "a notice" of its election of the fee schedule method or an exception to the minimum amount payable under that method.

Consistent with the plain language of the statute, the Legislature expressed no intent in the legislative history of the 2012 amendments to combine the two different methods when it renumbered subparagraphs (5)(a)1-5 or when it required "a notice" of the election in (5)(a)5. The 2012 amendments were based on the final version of

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House Bill 119, which originated in the House on September 2, 2011. The renumbering of subparagraphs (5)(a)1-5 already existed in that original bill. The Senate later introduced a companion bill (Senate Bill 1860) on January 9, 2012, and that Senate Bill has the same renumbering. Although the House Bill was ultimately enacted, both bills were considered in tandem.

The House and Senate staff analysis reports make no mention of the renumbering of the subparagraphs or otherwise suggest that the Legislature intended to combine the two methods. *See* Fla. Senate Bill Analysis & Fiscal Impact Statement, SB 1860 (Banking & Ins. Comm. Jan. 20, 2012) (www.flsenate.gov/ Session/Bill/2012/1860/Analyses/ 2012s1860.pre.bi.PDF); Fla. Senate Bill Analysis & Fiscal Impact Statement, CS/SB 1860 (Banking & Ins. Comm. Feb. 2, 2012) (www.flsenate.gov/Session/ Bill/2012/1860/Analyses/ 2012s1860.bi.PDF); Fla. Senate Bill Analysis & Fiscal Impact Statement, CS/SB 1860 (Budget Comm. Feb. 24, 2012) (www.flsenate.gov/Session/Bill/2012/1860/ Analyses/2012s1860.pre. bc.PDF); Fla. Senate Bill Analysis & Fiscal Impact Statement, CS/CS/SB 1860 (Budget Comm. March 2, 2012) (www.flsenate.gov/Session/Bill/2012/1860/ Analyses/2012s1860.bc.PDF). Likewise, the Final Bill Analysis of House Bill 119 makes no mention of renumbering the subparagraphs or combining the two methods, but instead explains that the 2012 amendment "retains aspects of the current PIP system" and that the only material change concerning the fee schedules is that

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insurers must amend their forms to use them. *See* House of Reps. Final Bill Analysis, CS/CS/HB 119 (May 7, 2012) (www.flsenate.gov/Session/Bill/2012/119/Analyses/h0119z1.INBS.PDF).

Surely, if the renumbering or any other aspect of the 2012 amendments were intended to combine the two methods, that intent would have been explained somewhere in these legislative history reports. Instead, the renumbering was deemed to be so insignificant that it was not even mentioned in those reports. As such, that renumbering did not alter the meaning of the 2008-2011 versions of subparagraphs (5)(a)2-5, as construed by the district courts of appeal in cases like *Nationwide*, *Kingsway*, and *DCI MRI*. If anything, the new notice requirement in current (5)(a)5 demonstrates the Legislature intended to codify *Kingsway*, which required PIP insurers to "clearly and unambiguously" make a "choice" between using the fee schedule method and the fact-dependent method, and intended to codify *DCI MRI*, which held the insurer had to provide notice of its intent to elect the fee schedule method. *See Essex*, 985 So.3d at 1043; *Brannon,* 711 So. 2d at 100.

In reviewing the Second District's statutory construction analysis, this Court should not lose sight of the Legislature's original purpose for adopting the fee schedule method in 2008, which was to give insurers the opportunity to elect a method that generates a fixed and predetermined amount payable, so that they could eliminate costly litigation over the reasonableness of the charge under the long-

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standing fact-dependent method. *See Florida Motor Vehicle No-Fault Law*, Report No. 2006-102, p. 96-97 ("fee schedule would … reduce litigation over the reasonableness of medical fees"); *Virtual II*, 90 So.3d at 323 (Legislature's 2008 fee schedule amendments to PIP statute "sought to address the enormous costs and inefficiencies of the law prior to amendment").

The Second District's conclusion that the Legislature intended to combine the two methods into a single method returns PIP to the pre-2008 situation with prolonged and costly litigation against insurers (like State Farm) who choose to "go to the mat" over the reasonableness of each medical bill. *See Palma*, 555 So.2d at 837. Nothing in the 2012 amendments or the legislative history indicates any intent to reinstate that pre-2008 situation.

(d) *Virtual III* and *Orthopedic* apply to State Farm Policy 9810A and require State Farm to elect between the two methods, without combining them

To bolster its conclusion that State Farm could combine both methods in its insurance policy rather than electing one method, the Second District held that *Virtual III* and *Orthopedic* do not apply to insurance policies issued after the 2012 amendment to the PIP statute. In support, the Second District first cited to *Orthopedic,* 212 So.2d "at 974." *See MRI Associates*, 252 So.3d at 777. However, nothing at page 974 of *Orthopedic* (or elsewhere) states that *Orthopedic* only applies to insurance policies issued before the 2012 amendment.

While the Second District also cited to *Virtual III*, 141 So.2d at 150, that

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portion of the *Virtual III* decision only referred to **Geico's** insurance policies adopted before July 1, 2012. In contrast, the *Orthopedic* decision does not limit its effect to policies issued before July 1, 2012, because *Orthopedic* did not involve **Geico's** insurance policies.

In concluding that *Virtual III* and *Orthopedic* do not apply to any insurance policies issued after the 2012 amendment to the PIP statute, the Second District relied upon a partial quote of a sentence in *Virtual III*, while overlooking another important part of the same sentence. According to *Virtual III*, the petitioner in that appeal (i.e., Geico) had recently amended its insurance policy to properly elect the fee schedule method, and so, in the sentence partially quoted at page 777 of the Second District's decision, this Court was explaining that the *Virtual III* decision would only apply to **Geico's** older policies, which were adopted before July 1, 2012. The complete version of this Court's explanatory sentence states:

> **Because the *GEICO policy* has since been amended to include an *election* of the Medicare fee schedules as *the* method of calculating reimbursements**, and the Legislature has now specifically incorporated a notice requirement into the PIP statute, effective July 1, 2012, see § 627.736(5)(a)5., Fla. Stat. (2012), ... our holding applies only to policies that were in effect from the effective date of the 2008 amendments to the PIP statute that first provided for the Medicare fee schedule methodology, which was January 1, 2008, through the effective date of the 2012 amendment, which was July 1, 2012.

Virtual III, 141 So.3d at 150 (emph. added; footnote omitted). Notably, the reasons expressed in *Virtual III* did not include any suggestion that the 2012 amendments

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combined the two methods as of July 1, 2012. Instead, *Virtual III* expressed that **Geico's** new policies now "include an *election* of the Medicare fee schedules *as **the** method* of calculating reimbursements," again reinforcing the notion that the policy must elect only one of the two different methods. In contrast, State Farm's policy does not elect only one method.

If this Court's *Virtual III* decision is not applicable to all insurance policies issued by all other insurance companies after July 1, 2012, there was no reason for this Court to explain that "the **GEICO** policy has since been amended to include an *election* of the Medicare fee schedules *as **the** method* of calculating reimbursements" and that the Legislature adopted "a notice requirement." These two reasons are not a logical basis to excuse all other insurance companies, such as State Farm, from having to make "an *election* of the Medicare fee schedules *as **the** method* of calculating reimbursements" in policies issued after July 1, 2012, as Geico's new policy had done.

Thus, this Court was not signaling that insurers could disregard the reasoning or holdings in *Virtual III* after July 1, 2012. Indeed, the continued applicability of *Virtual III* to insurance policies issued after July 1, 2012 was confirmed when this Court reworded the certified question and then answered it, as follows:

> ... We rephrase the certified question as follows:
>
> WITH RESPECT TO PIP **POLICIES ISSUED AFTER JANUARY 1, 2008**, MAY AN INSURER LIMIT REIMBURSEMENTS BASED

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> ON THE MEDICARE FEE SCHEDULES IDENTIFIED IN SECTION 627.736(5)(a), FLORIDA STATUTES, WITHOUT PROVIDING NOTICE IN ITS POLICY OF AN ELECTION TO USE THE MEDICARE FEE SCHEDULES AS THE BASIS FOR CALCULATING REIMBURSEMENTS?
>
> For the reasons more fully explained below, we agree with all of the appellate court decisions that have addressed this issue, and **we therefore answer the rephrased certified question in the negative**. We conclude that **notice to the insured, through an election in the policy, is necessary *because* the PIP statute, section 627.736, requires the insurer to pay for "reasonable expenses ... for medically necessary ... services," § 627.736(1)(a), Fla. Stat., but merely permits the insurer to use the Medicare fee schedules as a basis for limiting reimbursements**, *see* § 627.736(5)(a)2., Fla. Stat.

Virtual III, 141 So.3d at 150 (emph. added; footnote omitted). The rephrased certified question states that *Virtual III* applies to policies issued after January 1, 2008, without limiting that question to policies in effect before July 1, 2012. Importantly, the answer to that question explains that "an election in the policy" is required "*because*" the PIP statute provides for two different alternative methods.

Not surprisingly, this Court's subsequent decision in *Orthopedic* applied the *Virtual III* test to a different insurance company's policy and did not limit the application of the *Orthopedic* holdings to policies in effect before July 1, 2012. Nothing in the 2012 amendments legislatively abrogated or otherwise affected the reasoning applied in those cases or the prior district court decisions which they approved. Neither *Virtual III* nor *Orthopedic* suggests that the 2012 amendments combined the two methods. Thus, *Virtual III* and *Orthopedic* continue to control.

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The separate and distinct nature of the two methods after the 2012 amendments is also the premise of this Court's recent decision in *Florida Hospital*. In that case, this Court unanimously held the fee schedule method does not apply to medical expenses covered by the insured's PIP deductible, and any other expenses that the insured alone is obligated to pay which are not recoverable as PIP benefits under the insurance policy. *See Id.*, 260 So.3d at 224. Like the holdings in *Virtual III* and *Orthopedic,* this Court's holdings in *Florida Hospital* arise from the PIP statute's provisions that contemplate two separate and distinct methods. The separate and distinct nature of the two methods was unchanged by the 2012 amendments.

(e) The Second District misapprehended the distinction between the reasonable medical expenses coverage "mandate" and the fact-dependent reasonable amount "method"

Contrary to this Court's prior holdings in *Virtual III* and *Orthopedic*, the Second District rejected the notion that an insurer's policy must elect the fee schedules in lieu of the fact-dependent reasonable amount method. *MRI Associates,* 252 So.3d at 777. This position was premised on the Second District's erroneous assumption that the reasonable medical expenses coverage *mandate* described in section 627.736(1)(a) and the fact-dependent reasonable amount *method* described in section 627.736(5)(a), are the same thing.

In *Virtual III* and *Orthopedic*, this Court described the "reasonable medical expenses coverage *mandate*" as the portion of section 627.736(1)(a) that requires all

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PIP insurance policies to afford $10,000 of PIP coverage for 80% of reasonable medical expenses, and held that the fact-dependent *method* and the fee schedule *method* are two different alternative ways to satisfy that mandate. *See Virtual III*, 141 So.3d at 150 and 155-157; *Orthopedic*, 212 So.3d at 976.

Moreover, in *Orthopedic,* this Court held that a PIP insurance policy "cannot contain a statement that the insurer will not pay eighty percent of reasonable charges because no insurer can disclaim the PIP statute's reasonable medical expenses coverage *mandate*." *Id.*, 212 So.3d at 977. (emph. added). In direct and express conflict, the Second District held that a PIP insurer "may not disclaim *the fact-dependent calculation* of reasonable charges." *MRI Associates*, 252 So.3d at 778. In so holding, the Second District incorrectly assumed the reasonable medical expenses coverage *mandate* and the fact-dependent reasonable amount *method* are the same thing. Notably, the Second District had previously made the same mistake in *Allstate Fire & Casualty Insurance Co. v. Perez ex rel. Jeffrey Tedder, M.D., P.A.,* 111 So.3d 960, 962 (Fla. 2d DCA 2013). In *Virtual III*, this Court expressed its disagreement with the Second District's *Perez* decision and stated, "that is the very reason we rephrased the certified question in this case." *Virtual III,* at n. 8.

The "reasonable medical expenses coverage *mandate*" of section 627.736(1)(a) describes the $10,000 of mandated PIP coverage for 80% of reasonable medical expenses. That provision is not the same thing as the fact-

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dependent *method* that many courts and litigants commonly refer to as the "reasonable amount *method*" described in subsection (5)(a) of the PIP statute (formerly (5)(a)1).[4] This distinction was explained in *Virtual III*, when this Court rephrased the certified question to confirm that the "reasonable medical expenses coverage *mandate*" is not replaced by the fee schedule *method*, but can be *calculated* using either the fact-dependent *method* or the fee schedule *method*:

> We ... conclude that the 2008 amendments provided an alternative, permissive way for an insurer to calculate reimbursements to satisfy the PIP statute's reasonable medical expenses coverage mandate, but did not set forth the only methodology for doing so.

Virtual III, 141 So.3d at 156 (emph. added). *See also, Id.* at 157, n. 8 (expressing disagreement with Second District's conclusion in *Perez* that the 2008 fee schedule amendments allow an insurer to "either pay reasonable medical expenses ... or ... limit reimbursement according to the parameters of [former] subsection (5)(a)(2)").

There is only one "coverage mandate," but *Virtual III* clearly holds that there are two different alternative "methods" for satisfying that coverage mandate, and that insurers must make "a choice" between one method "or" the other. *Id.*, 141 So.3d at 156-157. Chief Justice Canady's dissent in *Virtual III* noted that the majority's decision rested on the premise that the two methods are "mutually

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[4] *See, e.g., Precision Diagnostic, Inc, a.a.o. Jean Belizaire v. State Farm Mut. Auto. Ins. Co.*, 25 Fla. L. Weekly Supp. 820a (Fla. Miami-Dade Cnty. Ct. Oct. 18, 2017) (referring to the fact-dependent method of section 627.736(5)(a) as the "reasonable amount method").

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exclusive." *Id.*, 141 So.3d at 160. Because the majority held that PIP insurers must make "a choice" between one method "or" the other, the "mutually exclusive" nature of the two methods is inescapable. *Id.*, 141 So.3d at 157 and 160.

Therefore, there is nothing objectionable about a PIP insurance policy including a statement promising to pay 80% of all reasonable medical expenses, because that is required by the reasonable medical expense coverage *mandate* of section 627.736(1)(a), which "is the heart of the PIP statute's coverage requirements." *Virtual III*, 141 So.3d at 155. A PIP insurance policy "cannot contain a statement that the insurer will not pay eighty percent of reasonable charges because no insurer can disclaim the PIP statute's reasonable medical expenses coverage *mandate*." *Orthopedic*, 212 So.3d at 977 (emph. added).

However, once the PIP insurance policy complies with the reasonable medical expenses coverage *mandate* by promising to pay 80% of reasonable medical expenses, the insurance policy must then take the additional step of electing only one of the two alternative *methods* in order to satisfy that *mandate*. *See Northwest Center for Integrative Med. & Rehab., Inc. v. State Farm Mut. Ins. Co.,* 214 So.3d 679, 680 and 682 (Fla. 4th DCA 2017), *rev. den.*, 2017 WL 3883668, (Fla. Sept. 6, 2017) (a PIP insurer "may elect to calculate medical reimbursements in one of two ways"); *Green v. State Farm Mut. Ins. Co.*, 225 So.3d 229, 230 (Fla. 4th DCA 2017) (a PIP insurer "may elect one of two methods"). As explained in *Orthopedic*, the

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fact-dependent method and the alternative fee schedule method each satisfy the PIP statute's reasonable medical expenses coverage mandate. *Id.*, 212 So.3d at 976.

Importantly, this Court ***never*** held in *Virtual III* or *Orthopedic* or *Florida Hospital* that the schedule of maximum charges can be commingled with the fact-dependent method described in subsection (5)(a) (formerly (5)(a)1) of the PIP statute. The Second District took that leap in logic on its own initiative. As a result, the Second District erroneously concluded that State Farm is allowed to combine the two methods, supposedly because State Farm "may not disclaim the fact dependent calculation." *MRI Associates*, 252 So.2d at 778. What State Farm is not allowed to disclaim is the reasonable medical expenses coverage *mandate*, which is different from the fact-dependent calculation *method*. The Second District misunderstood this distinction, and reached the wrong result.

PIP insurers must satisfy the *mandate* by making "a choice" between one *method* "or" the other. *Virtual III,* 141 So.3d at 157. That can only mean that the two methods are mutually exclusive. *Id.*, 141 So.3d at 160 (Canady, J., dissenting). So, if the fee schedule method is elected, the fact-dependent method must be disclaimed. But the Second District incorrectly concluded that the fact-dependent method must always be included in the policy, and can be limited by the fee schedule method.

Besides allowing insurers to combine the two methods, the Second District's decision is also internally inconsistent. On one hand, the court concluded that

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Orthopedic does not apply and that the two methods are no longer mutually exclusive. *MRI Associates,* 252 So.3d at 777-778. On the other hand, the Second District also concluded that an "election" is "mandatory" and "required" by *Orthopedic. MRI Associates,* 252 So.3d at 776, 778. If the two methods are no longer mutually exclusive and can now be combined by the 2012 amendments into a single method, there is no "election" to be made between the two methods.

(f) Contrary to the Second District's decision, State Farm Policy 9810A is not "more clear and unambiguous" than the Allstate policy that made the proper election in *Orthopedic*

In *Orthopedic,* this Court concluded that an Allstate insurance policy properly elected only the fee schedule method. In its decision below, the Second District concluded that State Farm Policy 9810A is "even more clear and unambiguous" than the Allstate policy in *Orthopedic*. *See MRI Associates*, 252 So.3d at 778. However, the Allstate insurance policy in *Orthopedic* and the State Farm insurance policy in this case are materially different.

Allstate's policy does not include the "reasonable charge" term and definition found in Policy Form 9810A, and that definition states State Farm can consider "one or more" of the seven elements listed therein, some of which are elements of the fact-dependent method and some of which are elements of the fee schedule method (R 221). In contrast to Policy Form 9810A (which purports to allow State Farm to use either method and to rely upon "one or more" of seven different elements), this

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Court explained that Allstate's policy "states in **mandatory language** that benefit payments **must** or **will** be made in accordance with [the fee schedule] limitations." *Orthopedic,* 212 So.3d at 979 (bold added; underline original).

Since the *Orthopedic* decision was issued, several trial judges have recognized the material differences between State Farm Policy Form 9810A and Allstate's policy language, and have correctly concluded that Policy Form 9810A does not satisfy the requirements of *Orthopedic*. *See e.g., Hess Spinal & Med. Centers of Plant City, a.a.o. Pamela Williams v. State Farm Mut. Auto. Ins. Co.,* 25 Fla. L. Weekly Supp. 108a, ¶3 (Fla. Hillsborough County Ct. Feb. 22, 2017); *Crespo & Associates, P.A., a.a.o. Albert Picallo v. State Farm Mut. Auto. Ins. Co.*, 25 Fla. L. Weekly Supp. 107d (Fla. Hillsborough County Ct. Mar. 7, 2017). The Second District overlooked those material differences, as well as this Court's reasons for approving the Allstate policy language in the *Orthopedic* decision.

(g) The language of State Farm's policy is not "virtually identical" to that of Section 627.736(5)(a)1.a-f

According to the Second District, State Farm's insurance policy language is permissible because it is "virtually identical to that of section 627.736(5)(a)(1)(a)-(f)." *MRI Associates,* 252 So.3d at 778. However, a side-by-side comparison reveals

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that State Farm's policy language is materially different from the statutory language:

Section 627.736(5)(a)1	Policy Form 9810A
The insurer may limit reimbursement **to** 80 percent of the following schedule of maximum charges ...	We will limit payment of Medical Expenses described in the Insuring Agreement of this policy's No-Fault Coverage to 80% of a properly billed and documented *reasonable charge*, **but in no event will we pay more than** 80% of the following No-Fault Act "schedule of maximum charges" .... (R 233; italics original; bold and underline added).

The material difference between the PIP statute and Policy Form 9810A is that the PIP statute allows PIP insurers to limit reimbursement "to" the schedule of maximum charges, but State Farm's "in no event will we pay more" provision is clearly intended to give State Farm the option to pay even less than the minimum amount payable under the schedule of maximum charges. From there, Policy Form 9810A also includes and emphasizes the defined term "*reasonable charge*" (R 233) and separately defines that term in a manner that deviates from the statute, by commingling elements of the fact-dependent method with elements of the fee schedule method (R 221).

In *Nationwide*, the Second District correctly held that the fee schedule method is "utilized in *computing the* ***minimum*** amount" payable by PIP insurance. *Id.,* 71 So.3d at 137 and 138 (emph. added). This is confirmed by section 627.736(5)(a), which authorizes insurers to limit reimbursement "to" the schedule of maximum

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charges, (5)(a)2 which sets the minimum amount under the 2007 fee schedules, and (5)(a)5 which requires "a notice" of intent to limit payments "pursuant to" the fee schedules. The last sentence of (5)(a)5 identifies only one exception: when the medical bill is less than the schedule of maximum charges, the insurer may pay the billed amount. If the Legislature did not intend to create a fixed schedule "pursuant to" which the insurer must pay the precise amounts computed thereunder, all of the many statutory terms and conditions in (5)(a)1-5 for calculating reimbursements under the schedule of maximum charges are meaningless and serve no purpose.

Make no mistake about it—State Farm is attempting to give itself the option to pay *less* than the minimum amount allowed by the fee schedule method. *See e.g., Feijoo v. State Farm Mut. Auto. Ins. Co.*, 24 Fla. L. Weekly Supp. 863a (Fla. Miami-Dade County Ct. Nov. 30, 2016) ("State Farm is attempting to have its cake and eat it too" by attempting to leave itself the option of choosing between the fact-dependent method and the fee schedule method if this would result in a lower reimbursement, instead of choosing one method to the exclusion of the other).

If the schedule of maximum charges is the *most* that State Farm will ever pay, then there will be times when State Farm could decide to pay a *lesser* amount (R 698, 842). If the policy allows the PIP insurer to reimburse an amount that is less than the schedule of maximum charges, then the insurer has not elected the fee schedule method. Moreover, State Farm's actual practice is inconsistent and

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unpredictable. In this case, State Farm paid *more* than the amount allowed by the schedule of maximum charges for every single medical bill for 19 patients (R 214, 269, 272-73, 275, 277, 280, 283, 286, 288, 291, 293, 296, 298, 301, 304, 307, 311, 314, 317, 320, 323, 326, 329). However, in many other cases, State Farm actually paid *less* than the minimum amount allowed by the schedule of maximum charges. *See, e.g., Crespo & Associates, P.A. a.a.o. Veronica Rondón v. State Farm Mut. Auto. Ins. Co.,* 23 Fla. L. Weekly 982b (Fla. Hillsborough County Ct. Dec. 18, 2015) (fee schedule required payment of $267.31, but State Farm merely paid $227.22); *Florida Emergency Physicians Kang & Associates, MD., P.A., a.a.o Jonathan Sias v. State Farm Mut. Auto. Ins. Co.*, 23 Fla. L. Weekly Supp. 1052a (Orange Cty Court, Feb. 10, 2016) (State Farm paid 15% less than 80% of 200% of participating physicians fee schedule); *Coastal Wellness Centers, Inc. v. State Farm Mut. Auto. Ins. Co.*, 2018 WL 3089321 (S.D. Fla. 2018) (State Farm improperly paid two percent less than 80% of the schedule of maximum charges).

Far from being "virtually identical" to the PIP statute, State Farm's policy turns the "schedule of maximum *charges*" into a schedule of maximum *reimbursements*, and purports to give State Farm unfettered discretion to pay whatever amount it wants by purporting to cap its *reimbursements* to no more than the schedule of maximum *charges*, while also allowing State Farm to pay less than that (R 698, 842). This is contrary to the plain language of section 627.736(5)(a)1, 2

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and 5, contrary to *Nationwide,* 71 So.3d at 137-138 (the fee schedule method is "utilized in computing the minimum amount" payable by PIP insurance), contrary to *Virtual III*, 141 So.3d at 150 (schedule of maximum charges may be used as a "method of *calculatin*g reimbursements to satisfy the PIP statute's reasonable medical expenses coverage mandate") (emph. added), and contrary to *Florida Hospital*, 260 So.3d at 223 ("in *calculating* reasonable medical expenses, section 627.736(5)(a)1. permits insurers to 'limit reimbursement *to* 80 percent of' a 'schedule of maximum charges.'") (emph. added).

By concluding that State Farm's policy language is virtually identical to the PIP statute, the Second District's opinion gave no meaning to the plain language of section 627.736(5)(a)1, 2, and 5, and side-stepped its own prior decision in *Nationwide*. If PIP insurers are always allowed to pay less than the schedule of maximum charges, there would be no reason for section 627.736(5)(a)1 to authorize insurers to limit reimbursement "to" the schedule of maximum charges, no reason for (5)(a)2 to state that the PIP insurer's payments "may not be less" than the allowable amounts under the 2007 fee schedules, no reason for (5)(a)5 to require PIP insurers to provide "a notice" of their intent to limit payments "pursuant to" the schedule of maximum charges--and for that matter, no reason for the entire schedule of maximum charges and the many terms and conditions tethered to it.

After suggesting that State Farm's policy language is "virtually identical" to

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section 627.736(5)(a)1, the Second District's ultimate conclusion is that "State Farm's policy includes mandatory language expressly limiting reimbursement for reasonable medical expenses ***to*** the schedule of maximum charges set forth in section 627.736(5)(a)(1)(a)-(f)...." *MRI Associates*, at 778 (emph. added). That is what *Virtual III, Orthopedic,* and *Florida Hospital* require, but that is ***not*** what State Farm's policy actually says. Instead of limiting reimbursement "to" the schedule of maximum charges, State Farm's policy language purports to give State Farm the unbridled discretion to pay less than that, in violation of *Nationwide*, and the plain language of section 627.736(5)(a)1, 2, and 5. Those statutory provisions prohibit PIP insurers from paying less than the schedule of maximum charges, unless the medical provider actually charged a lesser amount. *See* § 627.736(5)(a)5.

(h) State Farm's inconsistent and unpredictable payments are contrary to an election of the schedule of maximum charges

In an inconsistent and unpredictable fashion, State Farm sometimes pays the amount reflected on the schedule of maximum charges, but sometimes it pays less and sometimes it pays more. This case presents 19 examples of State Farm paying *more*. Other published cases provide examples of State Farm paying *less* than the schedule of maximum charges.

Policy Form 9810A states "*in no event*" will State Farm ever pay more than the schedule of maximum charges (R 232; emph. added), but that statement is blatantly false. The Health Care Provider's counterclaim for declaratory judgment

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explained that State Farm ***did pay more*** (R 135, 139, 142, 188, 192, 196). In fact, stipulated evidence proved that State Farm ***did pay more*** than the schedule of maximum charges based on the limiting charge fee schedule for every bill identified in its complaint for the 19 insured patients (R 209-10, 214, 269, 272-73, 275, 277, 280, 283, 286, 288, 291, 293, 296, 298, 301, 304, 307, 311, 314, 317, 320, 323, 326, 329). However, the amounts State Farm paid were far less than the billed amounts.

This is not an anomaly. It is well-documented that State Farm has relied on the limiting charge fee schedule in other published cases as well. *See, e.g., A-Plus Med. & Rehab Center, a.a.o. Jose Umbert v. State Farm Mut. Auto. Ins. Co.*, 24 Fla. L. Weekly Supp. 855a (Fla. Miami-Dade County Ct. Dec. 23, 2016); *Stand-Up MRI of Tallahassee, P.A., a.a.o. Sheri Andrews v. State Farm Mut. Auto. Ins. Co.*, 27 Fla. L. Weekly Supp. 93b (Fla. Broward County Ct. Mar. 20, 2019); *AFO Imaging, Inc., a.a.o. Asha Brown v. State Farm Mut. Auto. Ins. Co.,* 24 Fla. L. Weekly Supp. 165b (Fla. Hillsborough County Ct. March 15, 2016); *New Smyrna Imaging, LLC, a.a.o. Randy Durgin v. State Farm Mut. Auto. Ins. Co.,* 22 Fla. L. Weekly Supp. 717a (Fla. Volusia County Ct. Oct. 21, 2014).

Published cases also confirm that State Farm often pays *less* than 80% of the schedule of maximum charges. *See Rondon,* 23 Fla. L. Weekly 982b (fee schedule required payment of $267.31, but State Farm merely paid $227.22); *Sias*, 23 Fla. L. Weekly Supp. 1052a (State Farm paid 15% less than 80% of 200% of participating

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physicians fee schedule); *Coastal Wellness*, 2018 WL 3089321 (State Farm improperly paid two percent less than 80% of the schedule of maximum charges).

Simply stated, if State Farm had elected the fee schedule method, State Farm would actually be paying PIP claims at the precise fixed amounts indicated by the schedule of maximum charges. Instead, State Farm's policy language establishes an inconsistent and unpredictable payment scheme which presents significant adverse ramifications that are not mentioned in or reconciled by the Second District's erroneous decision below.

(i) The Second District's erroneous decision has significant ramifications

The ramifications of the Second District's erroneous decision to approve State Farm's combination of both methods in its policy—which State Farm relies upon to pay inconsistent and unpredictable amounts—are far-reaching and significant. As explained in *Virtual III*, an election by the insurer is required because the two different methods of calculating reimbursements have different consequences for the insured and the insured's healthcare provider, and both are entitled to know what amount may be billed, what amount the PIP insurer must pay, and what amount the insured patient must pay. *Id.* 141 So.3d at 159-160. If an insurer elects the fee schedule method, a health care provider is not permitted to "bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the

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coinsurance amount or maximum policy limits." *See* § 627.736(5)(a)4. But this balance-billing prohibition only applies "[i]f an insurer limits payment as authorized by subparagraph [(5)(a)]1". *See* § 627.736(5)(a)(4). That is, if an insurer *does not* limit payment according to the schedule of maximum charges, then balance-billing *is* permitted. So, when, as here, State Farm pays some amount that is different than the fixed amount set by the schedule of maximum charges, health care providers can balance-bill the insured patient for the entire unpaid balance of State Farm's portion of the bill that is supposed to be covered by PIP insurance.

However, if a health care provider is authorized to balance-bill the insured patient, but fails to do so, there are criminal consequences. Under section 817.234(7)(a), Florida Statutes, it is "insurance fraud" and a felony if a health care provider does not seek to collect the patient's portion of the total medical bill.

Because no one can determine or predict how State Farm will calculate its payment amount, the differing provisions of section 627.736(5)(a)4 and section 817.234(7)(a) place health care providers in the hopeless position of being unable to know how much they can lawfully charge and collect from their patients, without getting sued by the patient for improper balance-billing and without facing criminal charges for failing to balance-bill the patient. This is true whenever a PIP insurer purports to have elected the fee schedule method but pays an amount that deviates from the fee schedule method.

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In addition, State Farm's decision to pay a different amount opens the door to civil litigation over whether the charged amount was reasonable under the fact-dependent method of section 627.736(5)(a). The Legislature's primary purpose for adopting the alternative fee schedule method in the first place was to give PIP insurers the opportunity to clearly elect a method that generates a fixed and predetermined amount payable, which would eliminate litigation over the reasonableness of the amount under the fact-dependent method. *See Florida Motor Vehicle No-Fault Law*, Report No. 2006-102, at p. 96-97; *Virtual II,* 90 So.3d at 323. If the PIP insurer elects and pays the fixed amount indicated by the fee schedule method, there is no ability to litigate over the reasonableness of the amount paid by the PIP insurer. But if, as the Second District held, the two methods are combined into a single method, the pre-2008 system of costly litigation is revived when, as here, the PIP insurer pays an amount that differs from the fee schedule method but is less than the health care provider's billed amount.

Under this Court's decisions in *Virtual III, Orthopedic*, and *Florida Hospital*, these issues were put to rest because they uniformly acknowledge that there are two alternative methods and that the PIP insurer must make an unambiguous choice between one method or the other. *See also Northwest Center,* 214 So.3d at 680 and 682 (PIP insurer "may elect to calculate medical reimbursements in one of two ways"); *Green*, 225 So.3d at 230 (PIP insurer "may elect one of two methods").

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Nothing in the 2012 amendments or in the legislative history of those amendments indicate any intent to turn back the clock to the pre-2008 situation, where costly legal battles over the reasonableness of medical bills were the norm. *See Palma*, 555 So.2d at 836-837 (awarding successful plaintiff over $250,000 in legal fees over a $600 medical bill, where "State Farm decided to go to the mat" to dispute the PIP claim). Nothing in the 2012 amendments or in the legislative history of those amendments indicate any intent to allow PIP insurers to teeter back-and-forth between the two methods, which opens the door to litigation over the reasonable amount, exposes the insured patient to liability for the unpaid balance of the PIP insurer's portion of the medical bill, and exposes the health care provider to criminal charges for failing to pursue balance-billing against the insured patient. Yet, those are ramifications of the Second District's erroneous opinion.

Sadly, it appears that history is repeating itself. The Second District's decision provides a *déjà vu* situation, where that court is essentially taking the same position that Geico previously took in *Virtual III*, which this Court rejected:

> ... **GEICO takes the position that, pursuant to the 2008 amendments to the PIP statute, it was permitted to limit reimbursements in accordance with the Medicare fee schedules** because the Medicare fee schedules represent the Legislature's determination, consistent with the cost-cutting intent of the 2008 amendments, **of the proper way to determine the reasonableness of a medical expense. In other words, GEICO contends that there are not two methodologies for determining reasonableness.** Four district courts of appeal cases, however, have all concluded the opposite; that is, that there are two methodologies. *See Virtual II*, 90 So.3d at 323;

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DCI MRI, 79 So.3d at 842; *Virtual I*, 79 So.3d at 57-58; *Kingsway*, 63 So.3d at 67. We agree with the district court decisions in this line of cases and conclude that **the 2008 amendments provided an alternative, permissive way for an insurer to calculate reimbursements to satisfy the PIP statute's reasonable medical expenses coverage mandate, but did not set forth the only methodology for doing so.**

The 2008 fee schedule amendments used the word "may" to describe an insurer's ability to limit reimbursements based on the Medicare fee schedules. *See* [former] § 627.736(5)(a)2. [now (5)(a)l], Fla. Stat. As the Third District observed in *Virtual I*, if an insurer is not required to use the Medicare fee schedules as a method of calculating reimbursements, the insurer must have "recourse to some alternative means for determining a reimbursement amount" if it chooses not to use the Medicare fee schedules. *Virtual I,* 79 So.3d at 58; *see also Kingsway,* 63 So.3d at 67 (stating that the 2008 amendments plainly allow an insurer "to choose between two different payment calculation methodology options" based on the Legislature's use of the word "may," which "indicates that this option choice is not mandatory").

This alternative calculation mechanism is the same mechanism that was in place before the Legislature amended the PIP statute to incorporate the Medicare fee schedules: in the event of a dispute, a fact-finder must determine whether the amount billed was reasonable. **The permissive language of the 2008 amendments, therefore, plainly demonstrates that there *are* two different methodologies for calculating reimbursements to satisfy the PIP statute's reasonable medical expenses coverage mandate.** *See Kingsway*, 63 So.3d at 67.

Accordingly, we conclude that the 2008 amendments were clearly permissive and offered insurers **a choice** in dealing with their insureds as to whether to limit reimbursements based on the Medicare fee schedules **or** whether to continue to determine the reasonableness of provider charges for necessary medical services rendered to a PIP

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> insured based on the factors enumerated in [former] section 627.736(5)(a)l [now (5)(a)].

Virtual III, 141 So.3d at 156-157 (emph. added). The Second District's decision below contends that the 2012 amendments to the PIP statute should be construed the same way that Geico had previously argued that the 2008 amendments should be construed—such that the fee schedules could be used as a limitation on the fact-dependent method, and such that there are not two methodologies for determining reasonableness.

This Court rejected that same argument in *Virtual III*, and should reject it again in this case. Even after the 2012 amendments, the fee schedule provisions of the PIP statute are *still* "clearly permissive and offer[] insurers ***a choice*** in dealing with their insureds as to whether to limit reimbursements based on the Medicare fee schedules ***or*** whether to continue to determine the reasonableness of provider charges for necessary medical services rendered to a PIP insured based on the factors enumerated in" former section 627.736(5)(a), now (5)(a)1.

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CONCLUSION

The PIP statute and the case law construing it require PIP insurers to clearly and unambiguously elect one method or the other in the insurance policy. Because State Farm did not do so, it cannot use its unlawful hybrid method or the fee schedule method. Instead, by default, it must use the fact-dependent method. *Allstate Fire & Cas. Ins. v. Stand-Up MRI of Tallahassee, P.A.,* 188 So.3d 1, 2-3 (Fla. 1st DCA

2015) (fact-dependent method "is the default methodology for calculating PIP reimbursements"). Moreover, in actual practice, State Farm's payment amounts are inconsistent and unpredictable. The effect of the Second District's erroneous decision is to turn back the clock to the pre-2008 era of costly PIP litigation over the reasonableness of medical bills, and to hopelessly confuse health care providers and insured patients about the availability of balance-billing. That effect is contrary to the Legislature's primary purpose for adopting the alternative and permissive fee schedule method in 2008, and is unsupported by the 2012 amendments. Accordingly, this Court should answer the certified question in the negative, reverse the Second District's decision, and affirm the trial court's decision.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy hereof was **Electronically Filed** with the Clerk of the Court, and **Electronically Served** on the following persons on this 12th day of August, 2019:

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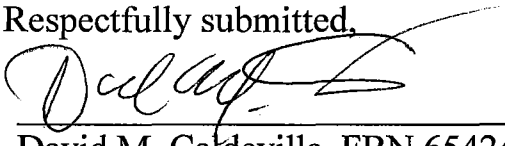
I HEREBY CERTIFY that this brief is printed in Times New Roman 14-point font, and complies with the font requirements of Fla. R. App. P. 9.210.

Respectfully submitted,



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