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IN THE SUPREME COURT OF FLORIDA

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CASE NO. SCOO-111
LOWER TRIBUNAL NO. 3D99-1348

3

UNITED AUTOMOBILE INSURANCE COMPANY

Petitioners,

vs.

MARISOL RODRIGUEZ,

Respondent.

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

AMENDED PETITIONER'S INITIAL BRIEF ON THE MERITS

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INTRODUCTION

In this appeal from a decision of the Third District Court of Appeal addressing a Certified Question from the County Court and affirming Final Summary Judgment in a PIP insurance coverage dispute, the appellant, United Automobile Insurance Company ("UAIC") will refer to the plaintiff, Marisol Rodriguez, as ("Rodriguez"). References to the record on appeal will be by the letter "R.__" with appropriate page numbers. All emphasis is added unless otherwise stated.

CERTIFICATE OF COMPLIANCE

Undersigned counsel hereby certifies that the size and style of type used in Petitioner's Brief is 14 point proportionately spaced Times Roman and is in compliance with this Court's Administrative Order dated July 13, 1998 regarding font requirements.

STATEMENT OF THE CASE AND FACTS

FACTS

As set forth in the trial court's Order below, "[t]he undisputed facts in this case are as follows:"

> 1. The plaintiff was involved in an automobile accident. She made a Personal Injury Protection ("PIP") claim to her insurer, the defendant.
>
> 2. The defendant has admitted coverage.

3. The defendant has waived all defenses, except as to the reasonableness, relation and medical necessity of the medical bills submitted.

4. The defendant received the plaintiffs PIP application on October 1, 1997.

5. The plaintiff sued to recover for unpaid medical bills that were provided to the defendant plus statutory interest at the rate of 10% per annum as required by Fla. Stat. § 627.736(4)(b) & (c).

6. The plaintiff and the defendant agree that the following medical bills were forwarded to the defendant that still remain unpaid.

7. On or about October 27, 1997, the defendant was provided with the plaintiffs claimed medical bills from Professional Medical Group in the amount of $3,580.00 for services rendered to the plaintiff from August 18, 1997 through October 20, 1997.

8. As of November 26, 1997, the defendant did not have a report from a licensed physician indicating that the plaintiffs claimed medical bills from Professional Medical Group in the amount of $3,580.00 were not reasonable, related or necessary.

9. On or about December 17, 1997, the defendant was provided with the plaintiffs claimed medical bills from Professional Medical Group in the amount of $5,075.00 [inclusive of the previous bill] for services rendered to the plaintiff from August 18, 1997 through November 24, 1997.

10. As of January 16, 1998, the defendant did not have a report from a licensed physician indicating that the plaintiffs claimed medical bills from Professional Medical Group in the amount of $5,075.00 were not reasonable, related or necessary.

11. On or about October 27, 1997, the defendant received the plaintiffs claimed medical bills from Professional Radiology for services rendered on August 18, 1997 totaling $665.00.

12. As of November 26, 1997, the defendant did not have a report from a licensed physician indicating that the plaintiffs claimed medical bills from Professional Radiology in the amount of $665.00 were not reasonable, related or necessary.

13. On or about December 17, 1997, the defendant received the plaintiffs claimed medical bills from Graciela Pozo, M D. for services recorded on August 18 and 28, 1997 totaling $300.00.

14. As of January 16, 1998, the defendant did not have a report from a licensed physician advising that the plaintiffs claimed medical bills from Graciela Pozo, M.D. in the amount of $300.00 were not reasonable, related or necessary.

15. The medical bills of Professional Medical Group and Professional Radiology were submitted to Dr. Dina Miller by the defendant for review on January 16, 1998 and the defendant received her report on January 19, 1998. This report was not received within 30 days of the Defendant receiving written notice of the fact of a covered loss and amount of same from the plaintiff.

16. All medical bills were paid in accordance with the report of Dr. Miller.

(R.206-208).

PROCEDURAL HISTORY

Rodriguez brought suit in the County Court seeking to recover unpaid personal injury protection benefits under her automobile insurance policy. (R. 1-2). After preliminary discovery, Rodriguez moved for Summary Judgment on the grounds that the defendant had 30 days from the dates of submission of the foregoing medical bills to pay the PIP claim unless, within that time, the defendant had reasonable proof to establish that it was not responsible for payment. (R.54-61).

In response, UAIC "concede[d] that it failed to obtain reasonable proof that it was not responsible for payment within the 30-day period. However, [it took] the position that failure to do so does not compel the defendant to pay the bills, but only subjects it to paying interest and attorney's fees should they eventually be found liable." (R.209).

UAIC relied, in part, on the following language in the Fifth District Court of Appeal's decision in *Jones v. State Farm Mut. Auto. Ins.* Co., 694 So. 2d 165 (Fla 5th DCA 1997), which held that failure to obtain such proof within 3 0 days exposes the insurer to statutory penalties attendant to an overdue claim, but does not deprive the insurer of the right to contest the claim:

> The best that even State Farm can say is that "State Farm had 'reasonable proof to *question* the relationship of Jones' left knee surgery. . . . "This does not meet the statutory test of "reasonable proof to establish that the insurer is not responsible for the payment. . . . " *Thus, State Farm is exposed to the statutory penalties attendant to an "overdue" claim. State Farm does not, however, lose its right to contest the claim. For this reason, State Farm's failure to pay the claim in thirty days does not relieve Jones from the obligation to submit to an independent medical examination.*

The trial judge rejected this argument and stated:

> This language in *Jones* appears to this Court to be *dicta.* The plaintiff in *Jones* never filed a Motion for Summary Judgment on the grounds that State Farm did not have reasonable proof within 30 days of receiving the PIP claim to deny the claim. The only issue on appeal was whether the trial court's granting of summary judgment in favor of the insurer for the insured's failure to appear at an IME was proper where the affidavits submitted by both sides failed to address the question

> whether the insured's refusal was reasonable in light of the fact that the examination was scheduled in a different municipality, in possible contravention of Fla. Stat. § 627.736(7)(a).
>
> Further, to interpret the PIP statute to require nothing more than interest and attorney's fees in the event an insurer loses, though an insurer fails to obtain reasonable proof to establish they are not responsible for payment within the 30 day time period, is to do nothing short of eviscerating the PIP statute. Interest and attorney's fees upon a finding of liability are a given fact in a claim by an insured against an insurer under the provisions of Fla. Stat. § 627.428. Therefore, the penalty in essence for failing to authenticate a claim, according to this position, would be nothing.

(R.209-2 10).

The trial court quoted from the Third District's decision in *Fortune Ins. Co. v. Pacheco,* 695 So. 2d 394 (Fla. 3d DCA 1997) and then noted:

> In *Pacheco,* Fortune sought to define the term reasonable proof of loss to include a burden upon the insured to provide medical records of its providers, and in so doing, sought to delay the time at which the 30 days to pay the claim would start to run. The *Pacheco* Court found that an insurer could not define and interpret the statute in its contract so as to circumvent long established case law that once an insurer receives notice of a loss and medical expenses, it must *pay* within 30 days unless it has obtained reasonable proof to establish that it is not responsible for the payment.
>
> This court is bound to follow the decisions of the Third District Court of Appeal and must, therefore, apply long established case law to the facts of this case in rendering its decision. Hence, *Pacheco* clearly states that the insurer must pay unless the insurer has reasonable proof to establish that it is not responsible for payment.

(R.210-211).

As the trial court noted, UAIC also cited "the cases of *Fortune Ins. Co. v. Everglades Diagnostics, Inc.,* 721 *So.* 2d *384* (4th DCA 1998), *United Automobile Ins.* Co. v. *Viles,* 726 So. 2d 320 (Fla. 3d DCA 1998), and *Derius v. Allstate Indemnity Co., 723 So.* 2d 271 (Fla. 4th DCA 1998) to support its position," (R.211). (emphasis in original). Nevertheless, in her Order Granting Final Summary Judgment, the trial court concluded:

> The *Everglades* case is distinguishable from the case at bar. The issue in *Everglades* was whether the insured could compel arbitration after 30 days had passed from the date when it received notice of a claim and the amount of same. The issue was not whether the insured was required to have "reasonable proof within *30* days. The *court* in *Everglades* held that the arbitration provision did not require the arbitration be requested within the 30-day provision and therefore, there is no "30-day requirement on the enforcement of the subsection (5) arbitration provision." *Everglades* at 3 85. The reasoning of the Fourth District Court of Appeal supports plaintiffs assertion that the insured must have "reasonable proof' within 30-days in order to contest the claim since both the 30-day provision and the "reasonable proof," language is contained in subsection (4) of the PIP statute.

(R.2 11).

The court also concluded that both *Viles* and *Derius* stand for the proposition that an insurer is required to have a report from a physician licensed under the same chapter as the insured's treating physician before the insurer can defend on the reasonableness, relation and medical necessity of the medical bills submitted by the insured. (R.212). Nevertheless, the court noted that *"these two cases are silent as to whether this report must be obtained within 30 days of receiving notice of the claim*

and the amount of *same,* but are adamant that an insured must comply with the statutory condition precedents before an insurer can terminate PIP benefits." (R.2 12). In deciding this question, the court concluded:

> When reading the PIP statutes *in pari materia,* the insurer must obtain the required report within 30 days. Obtaining the required report within 30 days, arguably provides the insurer with "reasonable proof for it to claim that it is not responsible for payment. Hence, absent such a report, the insurer has not obtained "reasonable proof' and must therefore, pay the claim.
>
> Given the Third District Court of Appeal's repeated references to a responsibility on the part of an insurer to pay within 30 days absent "reasonable proof' within the 30-days that it is not responsible for payment, this Court finds that it is bound by the reasoning of these cases.

(R.212-213).

Accordingly, the court concluded that UAIC owed the entire amount of benefits sought, as a matter of law, and awarded a judgment for principal, plus interest running from thirty days after receipt of the claims, for a total judgment of $5,489.64. (R.2 13).

Nevertheless, the judge, at the urging of Rodriguez's counsel, stated that she "would be delighted if an appellate court would give us some guidance" and, therefore, directed counsel to prepare a proposed order and a certified question to the Third District. (R.201). The certified question was stated as follows:

IN AN ACTION TO RECOVER MEDICAL BENEFITS IN A LAWSUIT UNDER FLA. STAT. § 627.736 WHERE THE ONLY DEFENSE BY AN INSURER IS THAT THE MEDICAL TREATMENT WAS NOT RELATED, NOT REASONABLE AND/OR NOT NECESSARY, MUST AN INSURER OBTAIN THE REPORT REQUIRED UNDER FLA. STAT. § 627.736(7) CONSTITUTING "REASONABLE PROOF" WITHIN 30 DAYS OF RECEIVING WRITTEN NOTICE OF THE FACT OF A COVERED LOSS AND OF THE AMOUNT OF SAME BEFORE IT CAN DEFEND ON THE BASIS THAT THE MEDICAL BILLS ARE NOT REASONABLE, NOT RELATED AND/OR NOT NECESSARY?

Thereafter, UAIC timely filed a notice to invoke discretionary jurisdiction of the Third District. (R. 16 l-l 71). On July 2, 1999, the District Court accepted jurisdiction and, on its own motion, consolidated the case with *Perez v. State Farm,* on the basis that both cases presented identical questions of law. (Al, 1-2). On October 13, 1999, the Third District entered the order under review. 746 So. 2d 1123 (Fla. 3d DCA 1999). After reciting the facts, the district court stated:

> The answer to the certified question in United Auto's appeal should be abundantly clear based on this court's unanimous *en banc* decision in *Fortune Ins. Co. v. Pacheco,* 695 So. 2d 394 (Fla. 3d DCA 1997). We answer this certified question with a resounding "yes," based on, now twenty-five years of established law and affirm the final summary judgment entered for Ms. Rodriguez. Based on the same reasoning we quash the Appellate Division decision challenged in Ms. Perez's certiorari petition. . . .

746 So. 2d at 1125. In support of its ruling, the Court found that:

> Section 627.736(4)(b), Florida Statutes (1997), provides that PIP insurance benefits "shall be overdue if not paid within 30 days after the insured is furnished with written notice of the fact of a covered loss and of the amount of same." This section also provides that "any payment

shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment, notwithstanding that written notice has been furnished to the insurer." *The PIP statute clearly requires that the insurer must obtain, within thirty days, a medical report providing "reasonable proof" that it is not responsible for payment. Here, the insurers failed to obtain such a report and, hence, must promptly pay the claim plus accrued interest.*

The insurers' contentions that while they failed to obtain a report within the statutory period, they can only be required to pay interest and attorney's fees is not persuasive. . . .

* * *

Based on *Pacheco,* the trial court in both cases before us correctly concluded that "reading the PIP statute *in pari materia,* the insurer must obtain the required report within 30 days." Having failed to do so, the insurers must pay the claims. The final summary judgment in Ms. Rodriguez's favor is therefore affirmed.

746 So. 2d at 1125-26.

A motion for rehearing, rehearing en banc, and for certification was filed and denied. Jurisdiction was sought in this Court, which accepted jurisdiction by order dated May 18, 2000.

ISSUE ON APPEAL

WHETHER AN INSURER IS REQUIRED TO OBTAIN THE REPORT REQUIRED UNDER FLORIDA STATUTE SECTION 627.736(7) WITHIN 30 DAYS OF RECEIVING WRITTEN NOTICE OF THE FACT OF A COVERED LOSS IN THE AMOUNT OF THE SAME IN ORDER TO DEFEND AN ACTION TO RECOVER MEDICAL BENEFITS UNDER SECTION 627.736 ON THE BASIS THAT THE MEDICAL BILLS ARE NOT REASONABLE, NOT RELATED, AND/OR NOT NECESSARY

SUMMARY OF THE ARGUMENT

The decision of the Third District under review should be overruled. It interprets the thirty day payment provisions of the PIP statutes in a manner that contradicts every other appellate court that has interpreted the same provisions. Further, it extends its own decisions and those of other courts well beyond the actual holdings of those cases and imposes an obligation on insurers that is simply not contemplated by the plain language of the PIP legislation. Under that legislation, an insurer is obligated to pay benefits that are otherwise payable under a PIP policy within thirty days, absent "reasonable proof" that the insurer is not liable. Absent such reasonable proof, an insurer is subject to specific statutory penalties of interest and attorneys fees. These provisions, which have remained virtually unchanged since 1971, and later provisions setting forth other possible actions or sanctions if the failure to pay constitutes a general business practice, provide the only penalty for lack of prompt payment. Beyond these penalties, the statutes neither change the burden of proof with respect to claims nor strip an insurer of its defenses to unreasonable, unnecessary, or unrelated charges.

Contrary to established rules of statutory construction, as applied correctly by other courts, the decision under review redefines the phrase "reasonable proof" under the thirty day rule to mean that only a physician's report contained in an unrelated section of the statutes related to the withdrawal of future PIP medical benefits will

constitute such proof. It then further redefines the statute to require such a report to be obtained within thirty days. If not, then an insurer is strictly liable for any charges even if they are unreasonable, unnecessary, unrelated or possibly fraudulent and regardless of whether the insured or the provider could ever meet its traditional burden of proof regarding those claimed expenses. Based upon a plain reading of the statute and traditional principles that prohibit courts from rewriting statutes in the guise of interpretation, this Court should reject the decision on review and adopt the well reasoned conclusions of other appellate courts that properly interpreted the PIP statutes at issue.

ARGUMENT

AN INSURER IS NOT REQUIRED TO OBTAIN THE REPORT REQUIRED UNDER FLORIDA STATUTE SECTION 627.736(7) WITHIN 30 DAYS OF RECEIVING WRITTEN NOTICE OF THE FACT OF A COVERED LOSS IN THE AMOUNT OF THE SAME IN ORDER TO DEFEND AN ACTION TO RECOVER MEDICAL BENEFITS UNDER SECTION 627.736 ON THE BASIS THAT THE MEDICAL BILLS ARE NOT REASONABLE, NOT RELATED, AND/OR NOT NECESSARY

Introduction

In the case *sub judice*, the court found that UAIC was obligated to pay medical expenses under its PIP coverage, without regard to whether these expenses were reasonable and necessary, or related to the car accident upon **which claim was made.** The court's determination was based solely upon the fact that, within thirty (30) days

after the claim had been made, UAIC had not obtained an expert report, which it considered documentation of "reasonable proof ', that the medical expenses claimed were not reasonable, necessary or related. This ruling misinterpreted the PIP statute and the law of the State of Florida. The Third District Court decision extended its earlier *en banc* ruling in *Fortune Ins. Co. v. Pacheco,* 695 So. 2d 394 (Fla. 3d DCA 1997) and held that the PIP insurer loses its right to defend a claim for benefits after thirty days have expired without payment, unless it has obtained such a report. Other District Courts, however, have read the same statutes differently, narrowly interpreted the *Pacheco* decision, and concluded that the failure to pay within thirty days only subjects an insurer to statutory penalties of interest and attorney's fees. It does not preclude an insurer from otherwise challenging the claim. *See Jones v. State Farm Mutual Automobile* Ins. Co., 694 So.2d 394 (Fla. 5th DCA 1997); *Fortune Insurance Co. v. Everglades Diagnostic, Inc.,* 721 *So.* 2d 384 (Fla. 4th DCA 1998); and *Derius v. Allstate Indemnity* Co., 723 So. 2d 271 (Fla. 4th DCA 1998). The Third District's decision misinterprets the relevant statute and engrafts an unrelated provision on the long-standing thirty-day rule. That conclusion is error and should be overturned.

<u>The Thirtv Dav Rule</u>

Section 627.736(4), Florida Statutes (1997), provides, *inter alia*:

> (4) BENEFITS; WHEN DUE. Benefits due from an insurer under ss. **627.730-627.740s. . .** shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and

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loss incurred which are covered by the policy issued under ss. *627.730-627.7405.*

* * *

(b) 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. . . . However, any payment shall not be deemed overdue when the insurer had *reasonable proof* to establish that the insurer is not responsible for the payment, notwithstanding that written notice has been furnished to the insurer. . . . .

(c) All overduepayments shall bear simple interest at the rate of 10 per cent per year.

* * *

(8) With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, the provisions of s. 627.428 shall apply.

These statutory provision first appeared in **1971** when the Motor Vehicle No-Fault Law was first enacted and have remained unchanged since.[1]

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[1] Although not applicable here, recent statutory amendments support UAIC's position regarding legislative intent. Section 627.736(5)(b), Fla. Stat. (Supp. 1998) was added in **1998** and seemingly responds, in part, to the issues addressed in *Pacheco.* It requires a provider — who under existing provisions may only charge a reasonable amount for the product, services and accommodations rendered — to submit their statement for charges directly to the insurer. Such services must be billed within thirty days of rendition "except for past due amounts previously billed on a timely basis" or within sixty days of the service if a notice of initiation of treatment is provided within twenty-one days. Absent such compliance, the injured party is not liable for and the provider shall not bill the injured party for charges not in compliance with this paragraph. For hospital charges and emergency services, paragraph (4)(b) notice is not deemed to be provided until specific statutory claim forms are submitted. Subsequent statutory notices regarding the insured's rights must contain language regarding these billing requirements. To further effectuate the existing provisions of subsection (6)(b), which already requires providers upon request of insurer, to furnish a written report together with a sworn statement that the

(continued...)

The statutory scheme provides that expenses payable pursuant to the statute are primary and are due and payable as loss accrues upon an insurance carrier's receipt of reasonable proof of both the fact of the covered loss, and the amount of expenses covered by the policy. § 627.736(4), Fla. Stat. (1997). Under these statutes, medical bills payable under Personal Injury Protection (PIP) coverage are those which arise from "the ownership, maintenance, or use of a motor vehicle." § 627.736(1). Fla. Stat. (1997). Such bills must constitute reasonable expenses for necessary medical services in order to be payable under the statute. § 627.736(1)(a), Fla. Stat. (1997). Indeed, physicians are prohibited from submitting charges that are not reasonable and necessary and, upon request, must certify the reasonableness and necessity of those charges. § 627.736(7), Florida Statutes (1997). Payments for medical expenses that are reasonable, necessary and related to a covered accident are deemed "overdue" if not paid within thirty (30) days after written notice of the fact of the covered loss. Nevertheless, covered expenses are not overdue if an insurer has reasonable proof to establish that it is otherwise not responsible for their payment. § 627.736(4)(b),

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[1](...continued)
services rendered were reasonable and necessary, an insurer can make an additional written request for documentation. That request extends the thirty-day time frame. If the district court's ruling below is upheld and an insurer cannot contest the claim absent a report obtained within thirty days of notice, then these newly enacted provisions, which are intended to provide an opportunity for insurers to adequately investigate claims and assure that only valid claims were being paid, would be thwarted.

Florida Statutes (1997). In order to insure prompt and speedy payment of covered expenses, the statutory scheme provides penalties for a wrongful denial or withholding of benefits. First, any payments deemed "overdue" are subject to interest at the rate of ten (10) percent per year. § 627.736(4)(c), Fla. Stat. (1997). Additionally, the provision providing for attorney's fees should an insurance carrier wrongfully deny a claim found in the general insurance statute has been grafted onto the PIP statute. § 627.736(8), Fla. Stat. (1997).[2]

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[2] The provision that overdue payment shall bear interest at the rate of 10% has been in existence since the statute was first enacted. At the time of its enactment, the statutory interest rate in Florida on judgments was 6%, § 55.03, Fla. Stat. (197 1). Therefore, the 10% interest provision is a penalty interest rate. In addition, the statutory judgment rate of interest is applicable to interest awards incorporated into final judgments, whereas the interest provision in the PIP statute is intended to compensate the insured for any payments made after the date payments are deemed overdue. Thus, it constitutes an additional amount owed if an insurer, without reasonable proof, subsequently decides to pay an overdue payment prior to suit or prior to judgment. Even though interest rates have fluctuated since 1971 and may, at the current time, equal the interest rate under the statute, as first enacted the provision for interest on overdue payments was a specific statutory penalty that applied regardless of whether suit was brought and judgment was later entered. In addition, the specific inclusion of the fee statutes in the PIP legislation suggest that the legislature intended it to be a penalty for wrongful denial of benefits and an incentive for prompt payment of reasonable charges. See, e.g., *GEICO v. Gonzalez,* 5 12 So. 2d 269,271 (Fla. 3d DCA 1987). In that respect, it follows the statutory goal of providing full recovery of major and salient economic losses to an insured, See *Chapman* v. *Dillon,* 415 So. 2d 12 (Fla. 1982) (even when the legislature lowered the PIP benefits and increased the PIP deductible, it did not violate the purposes behind the statute. As the court noted, its prior decision in *Lasky* was *not* predicated "upon a motorist being insured for the full amount of his medical expenses . . , Instead, the crux in *Lasky* was that all owners of motor vehicles were required to purchase insurance which would assure injured parties recovery of their major and salient

(continued.. .)

Only Charges That Arc Reasonable, Necessary and Related are Payable Under the PIP Law

The Relevant Burden of Proof

In PIP cases, the burden of proof is on the plaintiff to show that the charges are reasonable, necessary, and related to a covered accident. *Derius v. Allstate Indemnity* Co., 723 So. 2d 27 1 (Fla. *4th* DCA *1998). Derius* dealt with a withdrawal of benefits for chiropractic treatment. The insurer had initially paid benefits for three months, but discontinued payments after obtaining a medical examination and report of another chiropractor stating that additional treatments were neither reasonable nor necessary. The issue submitted the jury was whether any of the chiropractic treatment after June 7, 1994 was necessary and, if so, the total reasonable charges for that care. After a lengthy trial, the jury returned a verdict for Allstate. The county court certified a question, which the district court restated as follows.

> TO RECOVER MEDICAL BENEFITS IN A LAWSUIT UNDER SECTION 627.736, FLORIDA STATUTES (SUPP. 1994), MUST THE PLAINTIFF PROVE BY THE GREATER WEIGHT OF THE EVIDENCE THAT THE EXPENSES SOUGHT ARE BOTH REASONABLE AND FOR NECESSARY MEDICAL SERVICES?

723 So. 2d at 271 .[3]

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[2](...continued)
economic losses." *Id.* at 17.)

[3] In addition, the court was asked to answer another certified question whether jury instructions defining the word "necessary" in the statute were required.

The court answered the question in the affirmative. It first noted that personal injury protection benefits under the statute included 80% of all "reasonable expenses for necessary medical . . . services." *Id.* at 723. Thereafter, the court stated:

> *Under this statute, an insurer is not liable for any medical expense to the extent that it is not a reasonable charge for a particular service or if the service is not necessary.* In a lawsuit seeking benefits under the statute, *both reasonableness and necessity are essential elements of a plaintiffs case.* There is nothing in the PIP statute suggesting a legislative intent to alter the normal dynamics of a lawsuit by placing the burden on the defendant in a PIP case to prove that a proposed charge was unreasonable or that a given service was not necessary.

723 So. 2d at 272 (emphasis added). Thereafter, the court stated:

> *Whether a given medical service is "necessary" under section 627.736(1)(a) is a question offactfor the jury. Donovan v. State Farm Mut. Auto. Inc.* Co., 560 So. 2d thirty, 33 1 (Fla. 4th DCA 1990), held that a plaintiff could establish both the reasonableness of charges and the necessity of a medical service without expert testimony. Other cases have noted that the "necessity" of a medical service may also be proven through expert testimony. *See Farmer v. Protective Cas. Ins. Co., 530 So.* 2d *356* (Fla. 2d DCA 1988); *Banyas v. American Mut. Fire Ins. Co.,* 359 So. 2d 506,507 (Fla. 1st DCA 1978). *The current state of the law is that the issue of necessity in a PIP case is decided by factfinders on a case by case basis, depending on the specific evidence introduced at trial and the arguments of counsel.* The absence of a specific statutory definition accords each judge or jury broad discretion in arriving at a decision.

723 So. 2d at 274 (emphasis added).[4] Thus, under *Derius* nothing in the statute alters the plaintiffs burden.

Cases Interpreting the Thirty Day Rule

Dunmore v. Interstate Fire Insurance Co.

As early as 1974, the District Courts of Appeal interpreted the foregoing provisions to require that:

> the insurance company has thirty days in which to verify the claim after receipt of an application for benefits. There is no provision in the statute to toll this time limitation. The burden is clearly upon the insurer to authenticate the claim within the statutory time period.

Dunmore v. Interstate Fire Insurance Co,, 301 So. 2d 502 (Fla. 1 st DCA 1974). *Accord Margiotta v. State Farm Mut. Auto. Ins. Co,, 622 So.* 2d 135 (Fla. 4th DCA 1993); *Gov't. Empl. Ins. Co. v. Gonzalez,* 5 12 So. 2d 269 (Fla. 3d DCA 1987).

In 1995, the Third District reiterated the rule in *Dunmore.* In *Crooks v. State Farm Ins.* Co., 659 So. 2d 1266 (Fla. 3d DCA 1995), State Farm attempted toll the 30-day time provision by requiring that the medical bills be submitted on a particular in-house claims form. State Farm paid the claim after the initiation of the lawsuit but

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[4] In addition, it affirmed the denial of plaintiffs motion for directed verdict and held that:

> Allstate's reliance on the IME chiropractor's letter to withdraw payment to *Derius'* chiropractor was in compliance with the requirements of Section 627.736(7)(a).

Id. at 275.

argued that plaintiffs counsel was not entitled to attorney's fees because the time within which to pay the claim had been tolled due to plaintiffs failure to submit the bills on the in-house claims forms. The Third District disagreed with State Farm and once again expressed the principle that "the express terms of the statute [627.736(4)(b)] do not provide for tolling of the thirty day payment period under circumstances such as those in this case." *Crooks*, 659 So. 2d at 1268. Rather, the Third District pointed out that:

> the only provision in Section 627.736 which may arguably provide for a tolling of the thirty day payment period is the provision which states that an insurer's payments will not be overdue where the insurer has reasonable proof to establish that the insurer is not responsible for the payment. 627.736(4)(b), Fla. Stat. (1993). In the instant case, State Farm never claimed that it was not responsible for the requested claims. Instead, State Farm maintained that it would not recognize the claims until they were submitted on a particular in-house claims form. Since State Farm neither alleged nor attempted to prove that it had "reasonable proof' that it was not responsible for the underlying claims, and since the court made a finding that State Farm violated the provision of section 627.736(4)(b), the court's order denying attorney's fees must be reversed.

659 So. 2d at 1269.

Martinez v. Fortune Insurance Company

A later Fourth District case, *Martinez v. Fortune Insurance Company, 684 So.* 2d 201 (4th DCA 1996), also followed *Dunmore* and *Crook,* Like *Crook,* the insurance carrier in *Martinez* sought to toll the 30-day period while it requested a disability report from the treating doctor in order to pay a lost wage claim. The court

was asked to decide a question that the county court certified to be of great importance — *whether Section 627.736(4)(b) required a PIP insurer to pay claimed benefits within thirty days of receipt of the claim, rather than within thirty days of the receipt of the medical verification of the claim.* In *Martinez,* the insured was in an automobile accident on June 5, 1993. He sent the insured a no-fault application on July 30, 1993. The insurer specifically requested a disability evaluation report from the insured's physician, but received no response to that request or repeated efforts to obtain the report. In March, 1994, after the insurer still had not paid the claim, the insured filed suit. When the insurance company advised the insured's counsel that it had not paid because it did not receive the disability report from the doctor, the insured's counsel provided a copy of the report to the insurance company. Within thirty days of receiving that report, the claimed wage loss benefits were paid.

After analyzing the statute, the Fourth District court concluded that the second part of the applicable statute obligated the insurer to pay based upon receipt of a "written notice of loss" rather than on a "proof of loss." Accordingly, in direct response to the certified question, the court held that the insurer must pay the claimed benefits within thirty days of receipt of "written notice of the claim," not some later period based upon submission of additional proof. That question -- when the thirty days began to run — was the only issue the *Martinez* court decided. It did not involve the issue of the reasonableness of the payments sought nor whether the

failure to pay claims within thirty days waives any right to later assert in an action brought to recover benefits that the charges are not reasonable, related, or necessary.

Fortune Insurance Company v. Pacheco

Thereafter, the Third District considered *en banc the* case of *Fortune Insurance Company v. Pacheco, 695* So. 2d 394 (Fla. 3d DCA 1997). In *Pacheco,* the Third District was asked to answer a certified question that was identical to the question in *Martinez v. Fortune Insurance Company,* 684 So. 2d 201 (Fla. 4th DCA 1996).

The question, as rephrased by the court,[5] only decided whether a PIP insurer could define "reasonable proof of loss," in its policy to require the insurer to submit all supporting medical records before the statutory thirty-day payment period starts to run. 695 So. 2d at 394. In answering the question, the Third District aligned itself with the Fourth District's decision in *Martinez* and the First District's decision in *Dunmore v. Interstate Fire Ins.* Co., 301 So. 2d 502 (Fla. 1st DCA 1974).

The insurer had defined the phrase within its policy to require submission of a promptly completed application, a copy of the accident report, a listing of all medical expenses, and *all supporting medical records.* Thus, under the policy

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[5] The Third District restated the question as:

> Can a PIP insurer require an insured to submit all supporting medical records before the thirty (30) day time period for payment of the claim begins to run?

695 So. 2d at 394.

definition, the thirty-day provision did not begin to run when the bills were submitted, rather only when the bills with the "supporting medical records" were submitted. Moreover, even in instances where the bills were submitted (as were the circumstances in *Pacheco),* the 30-day time provision would be tolled until such time as the "supporting medical records" were submitted.[6] The Third District concluded that an insurer could not toll the time limit in this manner. The Third District applied existing authority and interpreted the statute to require payment of medical bills within thirty days of receipt of "reasonable proof' from the insurer, a phrase which the statute does not define. It concluded that the failure to pay within thirty days of the insured's written notification of the claim resulted in the claim being overdue. The Court stated:

> *Although it is entirely permissible for the insurer to require supporting medical records,* the insurer cannot require the claimant to furnish those records before the thirty-day period begins to run, The insured fulfills his obligation to furnish medical records upon signing a waiver of confidentiality that allows the insurer to procure the records directly from the provider, who has the records, and who awaits payment.

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[6] After suit was filed, the insurer paid the claim. The trial court then granted Pacheco's motion for summary judgment that sought attorney's fees due to the failure to pay within the statutory period. Thus, the only issue was whether the fee award was proper. The Third District affirmed the award of attorney's fees because the payment was statutorily overdue.

Id. at 396 (emphasis added). Accordingly, the Third District affirmed the judgment in favor of the insured and answered the certified question, as restated, in the negative.

Each of the foregoing cases, up to and including *Pachsco,* dealt with the tolling of the 30-day provision and whether an insurer could be relieved of the obligation to pay attorney's fees attendant to an overdue payment. Each time the District Courts of Appeal found that there were no circumstances pursuant to the statute that permitted the tolling of the 30-day provision. Up to that point, however, no District Court had addressed the issue certified and decided below — the effect of the thirty day rule on an insurer's ability to defend the amount of the claims, the reasonable proof needed to show that the payments sought were not reasonable, necessary, or related, and other available defenses to the claim.

Jones v. State Farm Mut. Auto. Ins. Co.

In 1997, the Fifth District Court of Appeal for the first time addressed the consequences that resulted if the carrier failed to obtain reasonable proof within 30 days from receipt of the medical bills that it was not responsible for payment of said bills. In *Jones v. State Farm Mut. Auto. Ins. Co.,* 694 So. 2d 165 (Fla. 5th DCA 1997), the Court concluded that the failure to timely respond to a claim for benefits, although exposing the insurer to the statutory penalties attendant to an overdue claim,

did not prevent the insured from defending the claim and arguing that there was no coverage under the policy.

In *Jones,* the accident occurred on April 1, 1995. The initial application for PIP benefits was made promptly on April 6, 1995. Benefits were thereafter paid through June 29, 1995. As a result of injuries that the insured's orthopedic surgeon related to the accident, the insured was scheduled for knee surgery on September 28, 1995. The bills for that surgery were submitted to the insurer on October 13, 1995. The insurer did not pay the bills within thirty days based upon its concerns that the surgery might not be related to the accident. It, therefore, scheduled the insured for a physical examination on November 30, 1995.

The insured responded with a four-count complaint against the insured, filed on November 20, 1995, that sought PIP benefits and alleged that the insured had violated § 627.737 because it failed to make payments on the claim within the thirty-day period provided for in the statute. *Jones,* 694 So. 2d at 166. As a result, the insured did not attend the physical examination. State Farm moved for summary judgment and asserted that it had been relieved of its obligation to the insured because of the insured's failure to attend that scheduled examination. In opposition, the insured submitted a report from his physician, which had been provided to State Farm on June 16, 1995. The report stated that, within a reasonable degree of medical probability, the insured's knee injury was related to the accident. Jones filed the

deposition transcript of the adjuster stating that she had made the decision to require further examination of Jones based on her belief that his condition was degenerative in nature. The trial court ultimately entered final summary judgment in favor of the insurer on all of the plaintiffs claims.

On appeal, the Court in *Jones* stated:

> Although we cannot credit Jones' contention that State Farm's failure to pay Jones' surgical bills within thirty days relieved him of any further obligation under the policy and requires that judgment be entered in his favor, we do agree with Jones that the summary judgment in favor of State Farm must be reversed. First of all, it is apparent that State Farm did not have reasonable proof that it was not responsible for payment of Jones' surgical bills. Despite State Farm's heroic effort on appeal to catalogue any fact or circumstance that might engender a suspicion that the knee surgery was not causally related to the accident, the best that even State Farm can say is that *"State Farm had 'reasonable proof to question the relationship of Jones' left knee surge ry. . . . " This does not meet the statuto y test of "reasonable proof to establish that the insurer is not responsible for the payment. . . . Thus, State Farm is exposed to the statutory penalties attendant to an "overdue" claim. State Farm does not, however, lose its right to contest the claim. For this reason, State Farm's failure to pay the claim in thirty days does not relieve Jones from the obligation to submit to an independent medical examination.*

166 So. 2d at 1 66.[7]

Thus, under *Jones,* the effect of non-compliance with the thirty-day payment requirement is clear. The failure to pay, unless there is reasonable proof to establish that the insurer is not responsible for the payment, exposes the insurer to the statutory

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[7] The only information State Farm had within 30 days was the adjuster's conclusion that the condition might have been degenerative.

penalties for an overdue claim. Nevertheless, it does not preclude the insurer from contesting the claim in the civil action. Neither *Martinez* nor *Pacheco* addressed this point or contradicted this legal conclusion.*

Fortune Insurance Co. v. Everglades Diagnostics, Inc.

In 1998, the Fourth District Court of Appeal reached a similar conclusion as the Court in *Jones* when it was faced with the question of whether the "30 day overdue" provision was applicable to demands for arbitration under Florida Statute 627.736(5). In *Fortune Insurance Co. v. Everglades Diagnostics, Inc., 721 So.* 2d 384 (Fla. 4th DCA 1998), the medical provider sued the insurance carrier for unpaid PIP benefits. The carrier moved to dismiss the lawsuit and compel arbitration. The medical provider responded by arguing that the carrier had to request arbitration within 30 days of receipt of the medical bills. The County Court, relying on *Pacheco,* agreed and held that the right to arbitration was lost because it was not demanded within 30 days of receiving the unpaid bills. The Circuit Court, Appellate Division, affirmed without a written opinion. On certiorari review, the Fourth District Court

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[8] The trial court and district court here determined, contrary to the *Jones* case, that medical expenses cannot be contested by an insurer unless it can show that it has obtained reasonable proof consisting of a physician's report within 30 days that it does not owe a claim. The courts noted the *Jones* decision, but felt that the language at issue was *dicta.* Nevertheless, even a cursory review of *Jones* demonstrates that the issue of whether the carrier loses the right to contest the claim, which it does not, was integral to the holding of the case.

of Appeal opined that *"the providers have simply read too much into the 30 day overdue provision."* The Court found that:

> Section 627.736(4)(b) says that PIP benefits paid under this section" shall be overdue if not paid within 30 days. . . . " 627.736(4)(c) says that "all overdue payments shall bear simple interest at the rate of 10 per cent per year." *As we understand these two provisions, they merely make the PIP insurer liable for interest on such claims if payment is not made within 30 days from notice. See Martinez v. Fortune Ins. Co., 684* So. 2d 201 (Fla. 4th DCA 1996) (statute makes claims for PIP benefits overdue when not paid within 30 days from receipt; failure of insured to pay claim within 30 days subjects insurer to interest on claim). *Hence, appropriately read, the function of the statute is to define when interest begins to accrue on unpaid PIP benefits.*

721 So. 2d at *384. See also, Allstate Ins. Co. v. Gulf Diagnostics, Inc., 724 So.* 2d 7 13 (Fla. 4th DCA 1999) (certiorari granted to compel arbitration pursuant to *Everglades).*

Thus, the Court, relying upon and indeed clarifying its earlier decision in *Martinez,* made a specific ruling with respect to the purpose and intent of the 30 day provision and the effects of the failure to comply with it. The Court also noted that, because subparagraph (4) did not mention the arbitration provisions of subparagraph (5), or vice versa, it was simply not free to engraft an additional consequence with respect to the 30 day provision onto the statute where none was otherwise stated. Indeed, it is for this reason that the *Everglades* Court distinguished the Third District's decision in *Pacheco,* which it found had no relevance to the arbitration issue. As the Court stated:

> *Pacheco* merely holds that the insured could not be required to submit all supporting medical records before the 30 day period for payment began to run.

721 So. 2d at 385, n.2.

The court in *Everglades* held that the arbitration provision under subsection (5) did not require a request for arbitration within thirty days because there is simply no thirty day requirement on the enforcement of that subsection. 72 1 So. 2d at 385. Similarly, there is also no relation between the report required under subsection (7) and the thirty-day requirement under subsection (4). Indeed, such argument makes no sense because section (7) deals specifically with the situation in which benefits are being paid, an IME review, either by physical examination or peer review is completed, and a report is provided that states that any prospective benefits should not be paid. Thus, it contemplates different circumstances than addressed in subsection (4), which merely establishes a due date for required payment, beyond which interest and fees apply to the overdue payments.

The Circuit Court Appellate Decisions

In the County Court Order affirmed below, Judge Milian had rejected UAIC's argument, distinguished *Everglades,* and found that the language in *Jones* was *dicta.* On May 7, 1999, two different panels of the Circuit Court, Appellate Division, rejected these arguments and adopted the same interpretation of the statute that UAIC proposed in the County Court, asserted in the District Court, and asserts here.

Ultimately, the Third District rejected these decisions, but the analysis in those cases comports with the statute and the existing authority.

State Farm Fire & Cas. Co v. Perez

In *State Farm Fire & Cas.* Co v. *Perez,* Case No. 97-3 83AP, 6 Fla. L. Weekly Supp. 47 1 (1 lth Cir., May 7, 1999), the Eleventh Judicial Circuit Court, Appellate Division, reversed an order of Judge Milian that, in most material respects, was identical to the order on appeal here. In *Perez,* the majority of the panel answered the question, which Judge Milian certified to the Third District in the instant case, in the negative. As framed by the Circuit Court, Appellate Division:

> This appeal raises the issue of whether an insurance company is barred from asserting a reasonableness defense to paying medical bills stemming from a covered accident when it does not have reasonable proof in its possession within thirty (30) days of receipt of the bills to establish that it is not responsible for the payment of the bills. In other words, is an insurance company barred from defending on the merits when the claim is overdue pursuant to F.S. Section 627.736(4)(b)?

The court's majority, with Judge Esquiroz dissenting, answered that question in the negative. As set forth in the opinion, the action arose out of an automobile accident in March 24, 1996. Five days following the accident, Perez sought medical treatment and ultimately received 54 treatments consisting of hot packs, cold packs, electrical stimulation, and ultrasound, with charges totaling $4,100.00. In response to the claim, State Farm arranged to have the insured examined by an independent medical examiner, which occurred 28 days after receipt of the bills. State Farm also provided

medical records to the independent medical examiner to seek an opinion as to reasonableness, necessity and relatedness of that treatment.

Thirty-six days after receiving the medical bills, State Farm received the IME report. The report concluded that the maximum benefit of physical therapy was achieved within 8 weeks after the accident and that the ultrasound provided the same relief as the hot packs and, therefore, constituted a duplication of services. The report also concluded that the nerve conduction studies were unwarranted. Based upon this IME and review of the records, State Farm made a reduced payment for the physical therapy treatment and denied payment for the nerve conduction studies.

Perez filed suit against State Farm seeking payment of the entirety of the medical expenses. After initial discovery had taken place, Perez moved for summary judgment. Perez asserted, as here, that State Farm did not have reasonable proof to establish it was not responsible for the payment of the plaintiffs claimed medical bills within 30 days of the receipt of the bills. Thus, Perez argued, State Farm was obligated to make the entire payment. Judge Milian granted the motion, holding that, because State Farm did not have the report in its possession until more than 30 days after receipt of the bills from the insured, Section 627.736 barred its defenses to the payment of any part of the claim. In doing so, she rejected the language of *Jones,* which she found to be *dicta.*

In reversing the trial court's Order, the Circuit Court appellate panel majority concluded that the statute provided that overdue payment shall bear simply interest at the rate of 10% per year. The panel determined that this was the only penalty, combined with attorney's fees, specified by the legislature for an insurer being overdue in making payments. As the Court noted:

> The statute does not provide that the insurer's defenses to paying a claim are barred if the insurer does not have reasonable proof within thirty (30) days of receiving the bills that it is not responsible. . . . The plain meaning of Florida Statutes, § 627.736(4) is that a PIP claim pending for more than thirty (30) days is overdue, subject to statutory interest and possible attorneys' fees. Although the lower court found that such sanctions were hollow given the apparent intent of the legislature to motivate insurance companies to pay PIP claims in a timely manner, it remains a legislative prerogative to enact more stringent consequences.

Id. at 472.[9] (emphasis in original). The Court also concluded that *Jones v. State Farm Mut. Auto. Ins. Co.,* 694 So. 2d 165 (Fla. 5th DCA 1997) ruled on the "very issue" before the Court. It harmonized the statutory language and the *Jones* holding with the holdings in *Dunmore, Crooks, Martinez,* and *Pacheco,* each of which it found to be "quite narrow and factually distinct" from the case before it. 6 Fla. L. Weekly Supp. at 472.[10] Thus, the Court concluded:

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[9] In a footnote, the Court noted that the 1998 legislature had enacted additional safeguards for insurance companies, insureds, and providers regarding PIP medical bills. See *supra* note 1.

[10] The Court correctly concluded that *Dunmore* dealt with an issue in which the insurer did not contest the entitlement to benefits, but disputed the allowance of (continued.. .)

> The plain language in Florida Statutes, Section 627.736(4)(b), together with the decision in *Jones v. State Farm Mut. Auto. Ins. Co., 694 So.* 2d 165 (Fla. 5th DCA 1997), compel this court to reverse the order granting summary judgment. We hold that an insurer may defend a PIP claim on the merits even when it does not have reasonable proof in its possession, within thirty (30) days of receiving a claim, that it is not responsible for payment of the claim. Such a claim is overdue, however, and the insured will be entitled to statutory interest and attorney's fees as provided by law.

Id. at 6. Ultimately, this decision was reversed by the Third District in the case consolidated with the instant action. That ruling was also error.

Allstate Ins. Co. v. Cofino

On the same day as Perez, a different panel of the Circuit Court, Appellate Division, decided the case of *Allstate Ins.* Co. v. *Cofino*, 6 Fla. L. Weekly Supp. 470 (11 th Cir. May 7, 1999). In that case, Cofino, the insured, received medical treatment

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[10](...continued)
attorney's fees. Thus, the only issue was whether attorney's fees were properly awarded and the Court's holding was that the admission of liability on the underlying claim was treated, in essence, as a judgment or decree in favor of the insured. With respect to Crooks, it noted that the insurer had paid the claim after plaintiff had filed suit and, once again, correctly concluded that the Court only addressed the issue of whether or not the plaintiff was entitled to attorney's fees. Similarly, the Court concluded that *Martinez* also involved a payment of the claim after the suit was initiated and that the District Court held that the insured was entitled to statutory interest and attorney's fees because of the late payment. No issue was presented, nor did the Court decide, whether the insurer's defense of the underlying claim was otherwise precluded. Finally, the Court distinguished the Third District's decision in *Pacheco* on the basis that the only issue was whether the insured was entitled to attorney's fees and noted that the Third District was not presented with the issue of whether the insurer could defend the merits of the claim after the 30 days expired. Perez, at 472.

after an automobile accident. The defendant, Allstate, provided him with personal injury protection insurance. Forty-six days after nerve conduction studies were performed, for a charge of $2,100, Cofmo submitted the bill to Allstate. In turn, Allstate sent the claim for independent review by another testing company. On July 26, the thirty-day period for the insurer to respond pursuant to the statute expired. However, it was not until September 12 that the independent review was completed and a report issued finding that the nerve testing was not medically necessary. As a result of this report, Allstate advised the provider that payment for the testing had been denied. Cofino filed suit for breach of contract alleging violation of the PIP statute. The County Court entered judgment in favor of the plaintiff for 80% of the disputed amount. Allstate appealed to the Circuit Court.

After quoting the provisions of Section 627.736, Florida Statutes, the appellate panel noted:

> The trial court apparently interpreted this statute to require say [sic] that payment be made within thirty days or the reasonable proof for denial be furnished within that same time period. The statute's language does not support this conclusion, It uses the word 'overdue" and is subject to not being 'overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment, ... ' *We interpret the statute to allow the required reasonable proof to be an element for the defendant to prove at trial. Therefore, summary judgment was not proper.*

Id. at 471. The Court noted that the closest cases cited by both parties hold that undisputed medical bills that are not paid on time subject insurers to attorney's fees

and interest, but not the liability effectuated here. *Id. (citing Pacheco, Crooks, Jones, Martinez,* and *Dunmore).* In addition, the Court quoted from *Everglades,* which found that the function of the statute is to defme when interest begins to accrue on unpaid PIP benefits. *Id.* As a result, the Court concluded that:

> Without any more definitive appellate guidance on this issue, we do not read this statute as creating any greater penalty for the insurance company than interest and fees. Therefore, we reverse the judgment of the trial court and remand, directing that the trial court vacate its Amended Final Summary Judgment and set this matter for trial to decide if Allstate's denial of the claim was medically reasonable.

Id. That decision was not appealed, but by implication has been overruled by the decision on review.

Appellate Decisions on Similar Statutes

In *Pioneer Life Insurance Co. v. Heidenfeldt,* 25 Fla. L. Weekly D23 1 (Fla. 2d DCA January 9, 2000), Heidenfeldt sued Pioneer Life seeking payment of medical costs under a Medicare supplement policy. Heidenfeldt moved for summary judgment on the basis that Pioneer Life was barred from denying coverage because it failed to comply with the 45-day notice requirement of section 627.613(2).[11] The

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[11] As stated by the Court:

Section 627.613, Florida Statutes (1997), provides, in part:

(1) The contract shall include the following provision:

"Time of Payment of Claims: After receiving written proof of loss, the

(continued..)

trial court agreed, entered a summary judgment against Pioneer Life as to liability, and a later final judgment awarding damages. On review in the Second District, the Court stated:

> This case requires us to determine whether the legislature intended that an insurance company's failure to comply with the 45-day notice requirement of section 627.613(2) prohibits the insurer from subsequently denying a claim on the basis that the benefits sought were expressly excluded from the insurance coverage. "When construing a statutory provision, legislative intent is the polestar that guides our inquiry and thus 'when the language of the statute is clear and unambiguous and conveys a clear and definite meaning, there is no occasion for resorting to the rules of statutory interpretation and construction."' *McLaughlin v. State, 72* 1 So. 2d 1170, 1172 (Fla. 1998) (quoting *A.R. Douglass, Inc. v. McRainey, 102 Fla. 1141, 13 7 So. 157,* 159 *(Flu. 1931)).*

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[11](...continued)

> insurer will pay monthly all benefits then due for (type of benefit). Benefits for any other loss covered by this policy will be paid as soon as the insurer receives proper written proof."
>
> (2) Health insurers shall reimburse all claims or any portion of any claim from an insured or an insured's assignees, for payment under a health insurance policy, within 45 days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer, the insured or the insured's assignees shall be notified, in writing, that the claim is contested or denied, within *45* days after receipt of the claim by the health insurer. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.
>
> *(6,) All overdue payments shall bear simple interest at the rate of 10 percent per year.*

Id. at D232.

25 Fla. L. Weekly at D23 1-32.

Pioneer Life asserted that the ten percent interest penalty imposed by subsection (6) was the only penalty the legislature intended an insurer to incur under section 627.613(2) for failing to comply with the notice requirements. The Court agreed:

> Pursuant to section 627.6 13(2), an insurer is required, within 45 days after receipt of a claim, to either reimburse the claim or notify the insured that the claim is contested or denied. Section 627.613(6) provides that all overdue payments will bear interest at the rate of ten percent. Thus, from a plain reading of the statute, it is clear that if an insurer fails to reimburse a claim or notify an insured that the claim is contested or denied within the 45-day time period, the insurer would be subject to the ten percent interest penalty. This appears to be the only penalty an insurer would be subject to under section 627.613.

Id. It believed that this conclusion was supported by the legislative history and also noted that the supreme court addressed a similar issue in *AIU Insurance Co. v. Block Marina Investment, Inc.,* 544 So. 2d 998 (Fla. 1989). [12] The Court concluded:

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[12] As the court stated:

> In AIU Insurance Co., the insurer advised the insured that it would provide a legal defense for the insured's claim although the claim was not covered under the parties' policy. See *id. at 999.* Two weeks prior to trial, the insurer informed the insured that it would not provide further defense because the claim was not covered by the policy. See *id.* The insurer's actions were in violation of section 627.426(2)(a), Florida Statutes (1985), which required the insurer to notify the insured of its decision not to defend within sixty days after its reservation letter and within thirty days before trial. See *id.*

(continued.. .)

> Based on our reading of section 627.6 13, we hold that a failure to comply with the notice requirements of section 627.613(2) does not result in a forfeiture of an insurer's right to deny benefits when the benefits sought are excluded from the insurance coverage. As the supreme court noted in AIU Insurance Co., to force coverage in this situation would in effect require an insurer to provide coverage for a risk it may never have agreed to undertake. See *AIU Ins. Co., 544 So. 2d at 999.*
>
> While we understand the trial court's disapproval of the actions of this insurer in delaying ten months before informing Heidenfeldt that her claim would be denied, the legislature did not intend section 627.6 *13* to act as a bar to denying uncovered claims. We, however, point out that there are other penalties insurers may be subject to, outside the scope of section 627.613, if they fail to comply with the requirements of the statute. n 1
>
> nl For example, Florida Administrative Code rule 4-142.01 1(9)(a)5 provides for penalties of up to $ 10,000 per violation for knowing and willful violations of section 627.6 13 and penalties of up to $2,000 per violation for nonwillful violations.

Id. The instant statute is similar to the statute at issue in the foregoing case and should be similarly interpreted.

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[12](...continued)

> The supreme court held that the insurer's failure to comply with the time requirements of section 627.426(2)(a) did not result in the insurer losing the right to refuse to cover the insured's defense where the coverage sought was expressly excluded or otherwise unavailable under the policy. See *id.* The supreme court reasoned that to rule otherwise would in effect "give insurance coverage to Block Marina . . . at a time when the marina operator's legal liability endorsement had been eliminated from the policy and the contract of insurance expressly excluded such losses from coverage." *Id.*

25 Fla.L.Weekly at D232.

The Instant Decision Misinterprets the Statute and Misapplies Existing Case Law

In its decision below, the District Court rejected the circuit court appellate division conclusions in the foregoing cases, rejected the decisions of other districts, and affirmed the County Court judges conclusion in *Rodriguez.* That conclusion arose from: (1) a determination that an insurer could only have "reasonable proof' that it was not liable for payment based upon reasonableness and necessity if it had an expert report required by section 627.736(7)(a); (2) a determination that such a report must be received within thirty days of receipt of the medical bills; and *(3)* a conclusion that the failure to obtain that report within thirty days requires an insurer to pay the claim regardless of whether the bills are reasonable and necessary. Those conclusions misinterpret the statute and are contrary to the current conclusions reached by other courts.

Section 62 7.736(7)(a), Florida Statutes (199 7)

Section 627.736(7)(a), Florida Statutes (1997), provides in pertinent part that:

> An insurer may not *withdraw* payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a report by a physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary.

The foregoing provision, which is the only provision in the PIP statute requiring an insurer to obtain a written report from a physician or other health care

provider in the same specialty as a physician providing treatment to an insured, did not become law in Florida under 1987.[13]

In *Allstate Ins. Co. v. Garrett, 550 So.* 2d 22 (Fla. 2d DCA 1989), the court concluded that this provision could not constitutionally be applied to a contract of insurance that had been entered into and was in effect for an automobile accident covered under the policy that occurred prior to the effective date of the statutory amendment. 550 So. 2d at 24. In analyzing the statute, the court stated:

> At that time Allstate's policy of insurance was issued, at the time of the accident resulting in Garrett's injuries, and at the time Allstate commenced the PIP payments for the benefit of Garrett, there was no limitation upon the type or speciality of qualified physicians upon whom Allstate could choose to rely in terminating PIP payments. After the date of the amendment to section 627.736(7)(a), Allstate was limited in basing its right to termination of benefit payments to a report from a physician "licensed" similarly to the "physician" whose treatment was sought to be terminated. All medical doctors of whatever specialty are licensed under the same chapter, Chapter 458, Florida Statutes. Chiropractors who are sometimes referred to in the other parts of the Florida Statutes as "physicians" are licensed under a separate chapter, chapter 460, Florida Statutes, and osteopathic physicians under chapter 459, Florida Statutes.

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[13] Chapter 87-282, Laws of Florida (1987). Thus, the suggestion by the Court in the instant case that the statutes should be read *inpari materia* is unsupportable, The thirty day rule in subsection (4) was in effect for 16 years before the amendments to subsection (7) were enacted. Accordingly, it cannot be assumed that the legislature intended them to be read together, particularly when there is no reference whatsoever to subsection (7) in subsection (4) or vice versa. The legislature did not choose to amend subsection (4), or even cross reference it at the time it amended subsection (7). Under the maxim that "the expression of one thing in a statute implies the exclusion of another" *Thayer v. State,* 335 So. 2d 815, 817 (Fla. 1976), it cannot be implied or assumed that they intended to do so.

> The apparent intent of the amendment to section 627.736(7)(a) is to prevent an insurer from using reports of a medical doctor as a basis for termination of payments to a chiropractor or osteopath and vice-versa.

550 So. 2d at 24 (footnote omitted). In addition, the Court stated:

> Section 627.736(7)(a) places no limitation upon the type of physician or physicians an insurer may choose to perform an independent mental or physical examination of an injured person covered by PIP insurance. *The limitation imposed by the amendment to section 627.736(7)(a) relates only to the type of physician whose report may be used to terminate benefits.*

550 So. 2d at 25.[14]

In the case of *Nationwide Mut. Fire Ins. Co. v. Southeast Diagnostics, Inc.,* 25 Fla. L. Weekly D3 16 (Fla. 4th DCA, February 2, 2000), __ So. 2d ___, (Fla. 4th DCA 2000), the Fourth District reviewed this statute in the context of a certified question from a county court with respect to whether an insurer was required to obtain a medical report based upon a physical exam of the insured before it may withdraw personal injury protection benefits. In deciding that a physical examination was not required, Judge Hazouri, writing for the Court, found that the provision at issue had first been added in a 1987 legislative session and stated:

> Prior to July 4, 1987, the effective date of the amendment to section 627.736(7)(a), there was neither a statutory nor contractual limitation

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[14] The court was not asked to and did not address the question of whether such a legislatively imposed imitation would be an impermissible and unconstitutional invasion of the Supreme Court's rulemaking authority or whether it is an unconstitutional limitation on the right of access to courts.

> regarding the withdrawal of PIP payments under a contract of insurance. We can find no language in the amendment that requires the medical report to be based upon a physical examination of the insured. Without express language from the legislature, there is no reason to conclude that a physical examination is required. We can envision may instances in which a competent physician upon reviewing medical records could conclude without the benefit of a physical examination that a treatment or test was not "reasonable, related, or necessary." If we follow Southeast's reasoning to its logical conclusion, every time a treating physician to whom a PIP carrier has paid benefits either conducted a diagnostic test or referred an insured for diagnostic testing, no matter how unconventional or medically unsound, a physician examination would be required before the payment could be refused.
>
> The legislature is assumed to have expressed its intent through the words found in the statute. If the language of a statute is clear and unambiguous, the legislative intent must be derived from the words used without involving construction or speculating as to what the legislative intended. *See Zuckerman* v. *Alter,* 615 So. 2d 66 1,663 (Fla. 1993). If the statute is clear and unambiguous, the court is not free to add words to steer it to a meaning which its plain wording does not supply, See *James Talcott, Inc. v. Bank of Miami,* 143 So. 2d 657,659 (Fla. 3d DCA 1962). The court is also not free to edit statutes or to add requirements that the legislature did not include. see *Meyer v. Caruso, 73* 1 So. 2d 118, 126 (Fla. 4th DCA 1999). We reverse the trial court's granting of the summary judgment on behalf of Southeast and remand for further proceedings consistent with this opinion.

28 Fla. L. Weekly at D3 17 (KLEIN, J., concurs. FARMER, J. concurs specially with opinion.)

In a special concurring opinion, Judge Farmer noted that the essential issue did not involve the PIP insurer who sought to withdraw payment of PIP benefits, but involved the question of whether payment for benefits should have even been started in the first place. *Id.* In evaluating this issue, Judge Farmer stated:

This provision plainly applies only to payments to a treating physician but not to other kinds of medical providers. Its import, moreover, turns on the meaning of the word *withdraw.*

Before assaying what the legislature meant in using the term *withdraw,* I pause to consider what words the drafters might have employed instead. They might, for example, have said "an insurer may not *make*[e.s.] payment...," or, more simply "an insurer may no *pay*[e.s.]...." In these hypothetical versions there would be no doubt that a physical examination and report are conditions precedent to *any* payment of a physician's bill under the PIP statute.

In the statute in question, however, the drafters have made the physical examination and report requirement depend on the term *withdraw.* If they had intended that the requirement of a prior physical examination must apply to any payment by an insurer to a physician they would have used one of the two versions I have suggested. Because they used *withdraw* in place of these alternative locutions, it is obvious to me that they did not intend that the physical examination requirement apply to a refusal to make any payment to a physician, especially in the first instance. In short, the term has a narrower application.

Id. at 3 18. The concurring judge also recited that words in statutes must be given their plain and ordinary meaning, unless otherwise specifically defined or a clear meaning to the contrary otherwise appears. *Id.* (citing *Green v. States, 604 So.* 2d 47 **1** (Fla. 1992). He then stated:

Applying the common and ordinary meaning to this statutory term, I think it is obvious that the legislature meant this sentence to apply only when the insurer has previously authorized the services of a particular physician by paying the initial and any subsequent bills, but later seeks to discontinue payment for future services by that physician.

The statute thus suggests as it purpose an aim to protect the reasonable expectations of both injured victim and physician. Once an

> insurer has initially approved the services of the physician as reasonably related to a covered claim and authorizes payment, both the insured and the physician reasonably expect continuing payment for the anticipated and customary course of services for the condition suffered by the patient. Such benefits ought not be withdrawn solely on the insurer's unilateral decision. In order to effect a withdrawal of benefits once started, the statute requires that the insurer receive a report based on a physical examination by a physician of the same specialty.

United Automobile Insurance Co. v. Viles

In *United Automobile Insurance* Co. v. *Viles*, *726* So. 2d 320 (Fla. 3d DCA 1998), *rev. denied. 735* So. 2d 1289 (Fla. 1999), the Third District held that in order to defend a claim for terminated benefits on the basis that medical charges were not reasonable and necessary, a report of a similar medical provider was required. The Court did not, however, conclude that such a report must be received within 30 days of receipt of the claim in order to deny the claim, as it did in the instant action.

As reflected in the county court order in *Viles,* UAIC initially paid $1100 to Viles for chiropractic treatment, but later withdrew and/or terminated future PIP benefits. The insured filed suit. United Auto affirmatively defended that the bills were fraudulent and not reasonably related to the accident in question. The case was tried before a jury. The plaintiff presented testimony from his treating doctor regarding the treatment and the charges, UAIC did not put on any expert testimony to contradict the plaintiffs treating physician's testimony regarding the amount of the bills or his testimony that the treatment given was reasonable, necessary and related.

In addition, no evidence was presented that UAIC had obtained a medical report from a licensed chiropractor before denying payment of the outstanding bills. The court found, however, that the plaintiffs expert witness and the plaintiff himself was effectively impeached at trial, which ultimately resulted in a jury verdict supporting UAIC's position. It concluded that, based upon the evidence, the jury was permitted to reduce the value of medical bills it found to be not reasonable, necessary, or related and to disregard any expert testimony it found not credible. Nevertheless, the plaintiff had moved for directed verdict based on the insurer's failure to obtain a physician's report prior to denying benefits in accordance with Florida Statute 627.736(7)(a). After first reserving on the motion, the County Court granted plaintiffs renewed motion "finding that United Auto was barred from raising the defense that the bills were not reasonable and necessary, because it failed to obtain a physician's report prior to denying payment." 726 So. 2d at 321. As a result, it overturned the jury's verdict, which had found that the reasonable amount due was less than the amount claimed and less than the insured's deductible. This would have resulted in a judgment for United Auto.

In reaching its conclusion, the county court analyzed the statutory language and its intent. As the Court found, "[t]he statute imposes a clear and absolute requirement before payment may be withdrawn, in the nature of a condition precedent," that the carrier must first obtain a report from a physician licensed in the same speciality

indicating what charges are unreasonable, unnecessary and/or unrelated. *Viles v. United Automobile Insurance* Co., 5 Fla. W. Supp. 170a, 172 (1 lth Judicial Circuit 1997) *(citing Pacheco, Dunmore* and *Jones).* Thus, it made little sense to allow an insurer to receive and review bills and elect, after the fact, to deny payment without the benefit of the required report, wait for suit to be filed, and thereafter seek to persuade the trier of fact as to the reasonableness and necessity of the services in question simply through cross examination and impeachment of the plaintiff or the plaintiffs treating physicians. In discussing the effect of such non-compliance on UAIC's ability to defend in the manner it chose, however, the Court stated:

> United argues that the statutory scheme permits it to raise common law defenses. Under the statutory scheme, the burden is on the insurer to authenticate the insured's claim within thirty days of notice of a claim. *Fortune Insurance Co. v. Ivan Pacheco,* 22 Fla. L. Weekly D1076 (Fla. 3d DCA 1997); *Dunmore v. Interstate Fire Ins. Co.,* 301 So. 2d 502 (Fla. 1 st DCA 1974). *If the claim is not timely paid, the insurer is exposed to the statutory penalties, which include interest and attorney's fees. See Jones v. State Farm Mutual Automobile Insurance Company,* 22 Fla. L. Weekly D1394 (Fla. 5th DCA, June 6, 1997); Section 627.736(4)(c), Fla. Stat. *If the claim is not timely paid, the insurer does not lose its right to contest the claim, however, and the insured is concomitantly not relieved of further obligation under the insurance policy. Id.*
>
> *Admittedly, the statute does not do away with United's common law defenses; rather, it imposes obligations on the insurer in reviewing and denying payment of claims submitted, and further establishes certain penalties for untimely payments,*

5 Fla. L. Weekly Supp. at 172.[15]

In its ruling, however, the County Court certified the following question:

> In any claim for personal injury protection benefits in which the insurance carrier has withdrawn, reduced benefits or denied further benefits, is it a condition precedent pursuant to Section 627.736(7)(a), Fla. Stat., that an insurer obtain a report by a physician licensed under the same chapter as the treating physician stating that the treatment was not reasonable, related or necessary in order for the insurance carrier to defend a suit for reduction, withdrawal or denial of further payments on the grounds of reasonableness, necessity, or relationship?

726 So. 2d at 320.

The Third District answered the certified question in the affirmative and affirmed the trial court's Order.[16] After discussing the relevant rules of statutory construction, particularly with respect to Florida's no-fault laws,[17] the Third District agreed with the trial court's "well reasoned analysis." The Court agreed that UAIC

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[15] The trial court also concluded that it was not necessary to have a physical examination performed. Rather, a peer review by an appropriate expert would have sufficed under the plain language of the statute. 5 Fla. L. Weekly Supp. at 172, n. 1. The holding in *Nationwide* confirms this conclusion.

[16] The Court stated:

> We affirm based on our conclusion that Section 627.736(7)(a), Florida Statutes (1997), requires an insurer to obtain a physician's report as a condition precedent to withdrawing or denying further medical payments.

Id. at 210.

[17] *Id.* at 321.

was required to obtain a physician's report before refusing to pay further medical bills. The Third District stated:

> The statute plainly provides that an insurer must first obtain the referenced report before electing to withdraw payment.

Id.

In so holding, the Third District quoted the "accurately stated" language of the Fourth District in *Derius v. Allstate Indemnity* Co., 723 So. 2d 271 (Fla. 4th DCA 1998), in which the Fourth District Court concluded that the statutory provision:

> 'sets up a procedural requirement that an insurer cannot withdraw payment of a treating physician unless the decision is supported by an expert that the treatment does not comply with the statutory criteria. If the insurer were to act without complying with such a procedural requirement, any termination of payment would be ineffective. In this procedural hurdle, we do not discern a legislative intent to alter the burden of proof in a lawsuit for PIP benefits. '

726 So. 2d at 321 *quoting Derius,* 732 So. 2d at 272. Accordingly, the Court agreed with the trial court's conclusion that because United Auto did not comply with the statutory condition precedent, termination of the benefits was ineffective and any reduction of the amount was properly precluded. Thus, under both *Derius* and *Viles*, the insurer must obtain a report before it can terminate benefits, but the plaintiff continues to have the burden of proof with respect to the reasonableness and necessity of medical charges sought by medical care providers.[18]

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[18] The court's ruling in the instant action, contrary to *Derius,* changes the relative (continued.. .)

In the instant action, there was no dispute that UAIC obtained a report that supported its conclusion that the claimed benefits were not reasonable and necessary (R. 105-113). Thus, the issue was not compliance with section 627.737(7)(a), but rather the effect of section 627.736(4)(b) related to the failure to make payment in thirty days. The district court concluded that in order to defend on the basis that charges were not reasonable and necessary, an insurer has to receive a report from an appropriate expert under subparagraph (7)(a) within thirty days. It interpreted the phrase "reasonable proof' under (4)(b), which excused lack of payment within thirty days, to mean that the only proof that is reasonable is a (7)(a) report. According to the court, absent receipt of that report in thirty days the payment is not only deemed overdue but the entire amounts claimed must be paid, with interest, as a matter of law and the reasonableness of the charges can never be challenged in a subsequent lawsuit. This holding, however, simply does not follow from *Pacheco, Viles, Jones, Derius*, or *Everglades.* It also completely contradicts the trial court's holding in *Viles*, which the Third District affirmed, regarding the sole effect of the failure to timely pay — the imposition of statutory penalties including interest and attorney's fees. It also contradicts *State Farm Fire & Cas.* Co v, *Perez,* Case No. 97-383AP, 6 Fla. L. Weekly Supp. 47 1, 471 (11 th Cir., May 7, 1999) which overruled the same

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[18](...continued)
burdens and order of proof under the statute.

conclusion and *Allstate* Ins. Co. v. *Cofino,* 6 Fla. L. Weekly Supp. 470 (11 th Cir. May 7, 1999), which reached the same results as *Perez.* Although receipt of such a report would certainly be reasonable proof that is sufficient to toll the thirty day payment period, the converse is not also true. There is simply no language within subsection (7) that adopts, engrafts or otherwise references the requirements of subsection (4) with respect to the thirty day time frame. If the legislature had intended to define "reasonable proof' in subsection (4) as only the expert report identified in subsection (7), it could have done so. Indeed, the phrase "reasonable proof' suggests that any proof that is reasonable, not just a report, may be sufficient. Under Florida law insurers are only obligated to pay a valid claim, and if those claims are not paid timely, the legislature has already determined the appropriate penalty.[19] The ruling of the trial court below does not correctly apply or interpret the law. In fact, it provides incentives to submit stale, inflated, or even fraudulent claims in the hope that the insurer will not obtain an expert review within thirty days and thereby increases, not reduces, the incentive for litigation.

Under *Jones,* the effect of non-compliance with the thirty-day payment requirement is clear -the failure to pay, unless there is reasonable proof to establish

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[19] The legislature also included a provision that establishes that a failure to timely pay claims with such frequency as to constitute a general business practice is deemed a violation of the insurance code, which subjects the recalcitrant insurer to potential additional penalties and actions. § 627.736(4)(g).

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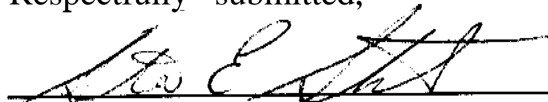
that the insurer is not responsible for the payment, exposes the insurer to the statutory penalties for an overdue claim, but does not preclude the insurer from contesting the claim in the civil action. Under *Fortune,* overdue payments are also only subject to statutory interest and fees and the thirty day provision is not engrafted onto other statutory requirements. Under *Derius,* the requirement of an expert report does not change the burdens of proof at trial. The decision on review rejects those rules and extends its *Pacheco* decision in a manner that not only alters the traditional burdens of proof, but engrafts the thirty day provisions of the statute in a manner that violates the plain terms of the statute. That conclusion was error and should be reversed.

CONCLUSION

WHEREFORE, UAIC respectfully requests that this Court reverse the Third District decision in the instant action and remand for further proceedings on the merits.

Respectfully submitted,



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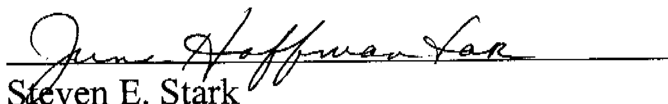
CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true and correct copy of the foregoing was mailed this 13th day of June, 2000 to: Amado Alan Alvarez, Esq., Law Offices of Alvarez & Alvarez-Zane, Sunset International Center, 7000 S.W. 97th Avenue, Suite 209, Miami, FL 33 173; Armando A. Brana, Esq., 3971 SW 8th Street, Suite 301, Coral Gables, FL 33 134-2937; Shelley Senecal, Esq., Hightower & Rudd, P.A., 100 North Biscayne Boulevard, 2300 New World Tower, Miami, FL 33 132; James K. Clark, Esq., Clark, Robb, Mason & Coulombe, Biscayne Building, Suite 720, 19 West Flagler Street, Miami, Florida 33130; and John H. Ruiz, Esq., 198 NW 37th Avenue, Miami, FL 33 125.



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