IN THE SUPREME COURT OF FLORIDA
TALLAHASSEE, FLORIDA

MAURICE DERIUS,	:	
	:	
Appellee/Petitioner,	:	
	:	
vs.	:	SC Case No.: SC01-296
	:	
ALLSTATE INDEMNITY COMPANY,	:	
	:	
Appellant/Respondent.	:	
	:	
_____	:	

AMENDED
AMICUS BRIEF ON THE MERITS OF
PROGRESSIVE INSURANCE COMPANIES AND
FLORIDA DEFENSE LAWYERS' ASSOCIATION
(AMENDED AS TO COVER PAGE ONLY)

Tracy Raffles Gunn, Esquire
FOWLER WHITE BOGGS BANKER P.A.
Post Office Box 1438
Tampa, FL 33601
813 228-7411
Florida Bar No.: 984371
Attorneys for Progressive Insurance Companies and Florida Defense Lawyers Association

STATEMENT OF THE CASE AND FACTS

Amici curiae, Progressive Insurance Companies and the Florida Defense Lawyers' Association, adopt the Statement of the Case and Facts as presented by Allstate Indemnity Company.

SUMMARY OF THE ARGUMENT

Petitioner has abandoned the issues he raised in the Fourth District Court of Appeal. In this case, he attempts to raise new issues which are not dispositive of this matter.

Petitioner asks this Court to determine that a physician's report as defined in subsection (7) of the PIP statute, while not required within the 30 day period of subsection (4), is required by the time of summary judgment. However, Petitioner fails to recognize the distinction between a reduction of a claim and a withdrawal of benefits.

Withdrawal of the future stream of benefits is vastly different than denial or reduction of a particular claim for a single, specific treatment. Subsection (7)(a) applies to the former, while subsection (4)(b) applies to the latter. A physician's report under subsection (7) is simply not required to reduce a claim, at any time. Whether a report must be produced by the time of summary judgment in a withdrawal case is not at issue in this case.

ARGUMENT

I. THIS COURT SHOULD NOT CREATE A NEW DEADLINE FOR OBTAINING A SUBSECTION (7) PHYSICIAN'S REPORT, ESPECIALLY SINCE THIS CASE INVOLVES A REDUCTION OF A CLAIM NOT A WITHDRAWAL OF BENEFITS.

The original issues in this case have been eliminated by this Court's decision in United Automobile Insurance Company v. Rodriguez, 2001 Westlaw 1380001 (Fla. Nov. 8, 2001). Petitioner in this case claimed at both the trial court and the Fourth District Court of Appeal that an insurer must obtain a physician's report as defined in Florida Statutes section 627.736 (7)(a) ("the PIP statute") in order to comply with the "reasonable proof" requirements of subsection (4)(b) of that statute. Petitioner also contended that if the carrier failed to obtain such "reasonable proof" within the 30 day period provided in subsection (4)(b), it would forfeit all right to contest the claim.

Both of these arguments were flatly rejected by the Fourth District below and by this Court in Rodriguez. Florida law is now clear that subsection (4)'s "reasonable proof" does not require a subsection (7) medical report. Likewise, it is now clear that an insurer's failure to comply with the "reasonable proof" requirement of subsection (4) does not strip it of its right to contest the claim. Rather, if the claim was in fact

reasonable, necessary and related, and if the insurer did not comply with subsection (4), the carrier will owe interest and attorneys fees.

Apparently recognizing that this Court's decision in Rodriguez eliminated all the arguments he raised below, Petitioner now contends that this case presents an "ancillary" issue. Petitioner's Brief, page 3. Petitioner asks this Court to determine that the subsection (7) physician's report, while not required within 30 days, is still required to contest reasonableness, necessity, and relatedness of the claim at the time of summary judgment. While this case involves only a reduction of submitted bills, Petitioner asks this Court to address the issue in cases of denial, withdrawal or termination as well.

Petitioner's request must be denied for several reasons. First, this Court has already correctly determined that a physician's report is simply not required to reduce a bill as opposed to withdrawing benefits. There is no need to decide the time frame for obtaining the report because the report is simply not required at all in reduction cases. In failing to acknowledge the difference between a reduction of a claim and a termination or withdrawal of benefits, Petitioner is improperly

asking this Court to address issues that are not raised in this case.

Furthermore, there is no requirement of any proof by the Defendant at summary judgment. If this were a withdrawal of benefits case instead of a reduction case, and if the case had gone to trial instead of summary judgment, those issues may be ripe. In this case, however, the dispositive issues have already been determined in Rodriguez. In order to fully explain the defects in Petitioner's argument, the court must begin with the statute.

A. "WITHDRAWAL" OR TERMINATION OF BENEFITS IS NOT THE SAME AS DENIAL OR REDUCTION OF A SPECIFIC CLAIM

The primary defect in Petitioner's argument in this case is his failure to give meaning to the vastly different terms used in each part of the statute. Florida Statutes section 627.736 (4)(b) sets out the procedure for payment, reduction or denial of a specific claim. Subsection (7)(a) relates only to withdrawal or termination of a future stream of benefits. Subsection (7)(a) refers only to whether the treatment is unreasonable, unrelated, or unnecessary. It does not relate to whether specific charges are reasonable. Neither subsection refers to the other, and neither purports to impose any requirements on cases controlled by the other subsection. See

Beach v. Great Western Bank, 692 So. 2d 146 (Fla. 1997), affirmed, 118 S.Ct. 1408 (it is presumed that the legislature acted intentionally if different terms are used in different parts of a statute).

This Court recognized in Rodriguez that there is an important distinction between withdrawal or termination of benefits and the denial or reduction of a specific claim or bill. Rodriguez, at *5 (Pariente, J., concurring) ("As for section 627.736(7)(a), this statute deals exclusively with the requirements for withdrawal of payment."). It is absolutely necessary to continue to recognize the difference between denial of a specific claim and termination of future benefits. A patient having one claim denied will still submit a claim for his next treatment. In many cases, some claims will be denied or reduced and others will be paid. In contrast, a withdrawal terminates all benefits from the effective date forward, and ends the coverage for the entire course of treatment. See Peachtree Casualty Ins. Co. v. Walden, 2000 Fla. App. LEXIS 2174 (Fla. 5th DCA March 3, 2000) (explaining that a withdrawal of benefits is a repudiation of the entire contract); Sensory Neurodiagnostics v. State Farm Mutual Automobile Ins. Co., Fla. L. Weekly Sup. 648 (Thirteenth Judicial Circuit, May 25, 1999)

(explaining the difference between termination of benefits and denial of a claim).

This is a reduction case. There are no issues of withdrawal or termination of benefits presented here. Derius, 773 So.2d 1190, 1991. ("In the instant case, we deal only with the reduction of a physician's bill.")

B. A PHYSICIAN'S REPORT IS NOT REQUIRED TO REDUCE A CLAIM

Petitioner's argument that a carrier must obtain a subsection (7) physician's report by the time of summary judgment or final hearing presupposes that a report is required at all. A subsection (7) physician's report is simply not required to reduce a given claim, as opposed to withdrawing benefits. See Rodriguez, at *5 (Pariente, J., concurring) ("Nothing in the language of section 627.736(4)(b) suggests that the "reasonable proof" necessary to avoid "overdue" status is limited to the "report" necessary to "withdraw" payment of a treating physician under section 627.736(7)(a)."). Even the dissenting opinion in Rodriguez agrees that in a reduction, as opposed to withdrawal case, it simply makes no sense to require a report. Justice Lewis' dissent notes:

> It is important to note that subsection (7) covers situations where the insurer under a PIP policy seeks to withdraw payment of a treating physician on the basis that the *treatment,* as opposed to the *charge* for

> that treatment, is not reasonable, related, or necessary. That is, subsection (7) requires an insurance company to obtain a report from a physician licensed under the same statute as the treating physician only in those situations where the insurer wishes to challenge the reasonableness, relatedness, or necessity of the services and treatment rendered. To be sure, subsection (7) does not require insurance companies to obtain a similar report when its challenge is based on the bill itself (i.e., the *amount* being charged).

Rodriguez, 2001 WL 1380001, 26 Fla. L. Weekly S747, at n. 14.

Petitioner relies heavily on the Third District's decision in United Automobile Insurance Company v. Viles, 726 So. 2d 320 (Fla. 3d DCA 1998). Petitioner contends that Viles establishes that a physician's report is a "condition precedent" to both a reduction of a claim and a withdrawal of benefits.

The court in Viles does appear to use the terms "withdrawal," "reduction" and "denial" interchangeably. This is erroneous. The sole issue in Viles was a withdrawal of all future benefits. Any discussion by that court of reduction or denial of claims is dicta. In Viles, there was no issue regarding reduction or denial of a specific claim, and Viles can only be held to apply to withdrawal cases. The Fourth District below properly held that Viles does not apply to this reduction case.

Furthermore, while Viles was not expressly overruled by this Court in Rodriguez, Viles cannot be interpreted as Petitioner

argues in light of this Court's decision in Rodriguez. Rodriguez establishes that there is no condition precedent to the carrier's ability to defend a reduction case.

Petitioner claims that the Derius court "recognized that the legislative purpose of [subsection 7] is to provide medical oversight to an insurance carrier's determination not to pay for or reduce payment on submitted medical bills." Petitioner's Brief, page 9 (emphasis supplied). This is simply incorrect. The Derius court clearly distinguished between a withdrawal and a reduction. In fact, that was the court's stated basis for distinguishing the present case from the Viles situation. Both the Fourth District below and this Court in Rodriguez made clear that "medical oversight," i.e., the subsection (7) physician's report, is not required to determine whether a bill is excessive.

On page 9, Petitioner claims (without citation) that there is a "long recognized . . . difficulty . . . with non-medical personnel making decisions about the care of patients." Petitioner again fails to recognize that the case under review does not involve patient care. It involves the extent to which the insurance company will pay a certain charge for a certain procedure or item. The carrier does not, in a reduction case, determine whether or not the care will continue. That is a

withdrawal case. The carrier does not, in a reduction case, wholly deny coverage for the entire procedure. The insured gets the treatment. The provider simply does not get paid more than the proper amount for that treatment.

A carrier may agree that treatment is necessary and related, but may dispute the amount charged (a "reduction" case). In many such cases, the reasonableness of the charge can validly be determined without medical expertise, especially where the necessity of the treatment is not at issue. In fact, the court noted in Nationwide Mutual Fire Ins. Co. v. Southeast Diagnostics, 766 So.2d 229 (Fla. 4th 2000), that a physical exam is not necessary in many cases to determine if a claim is reasonable, necessary, and related to the accident.

However, under Petitioner's analysis, a carrier could not determine that a $100.00 charge for an aspirin was not "reasonable" without obtaining a physician's report to that effect, even if the carrier had no question that the patient needed the aspirin to treat injuries related to the accident.

One of the primary rules of statutory construction is that a statute cannot be given a meaning that would lead to absurd results. See Weber v. Dobbins, 616 So. 2d 956, 958 (Fla. 1993); Druny v. Harding, 461 So. 2d 104 (Fla. 1984); City of St. Petersburg v. Siebold, 48 So. 2d 291 (Fla. 1950). To accept

Petitioner's argument that a physicians's report is required to reduce payment would lead to absurd results.

Similarly, a plaintiff could file a claim for injuries sustained in an accident for which there is no coverage under the policy, and the carrier would be bound to pay the uncovered claim unless it obtained a medical report by the time of summary judgment. Such a case clearly involves no medical issue, and it would be absurd to require a medical report in such a case.

These types of absurd results are the product of the fact that the physician report requirement is intended to apply only to the decision to terminate benefits, not the decision to pay, reduce or deny a specific claim. The legislature has determined that terminating all future care is a medical question requiring medical input, while decisions as to specific claims require only "reasonable proof." This Court has already held in Rodriguez that this distinction must be enforced. Petitioner's entire argument depends on a faulty presumption - that a report is ever required in reduction cases.

C. THIS COURT SHOULD DISMISS THIS CASE, OR AT LEAST DECLINE TO ADDRESS THE "ANCILLARY" ISSUES PRESENTED BY PETITIONER

It is respectfully requested that this Court should dismiss this case. Petitioner sought review on the basis of conflict with Perez v. State Farm Fire and Casualty Company, 746 So.2d

1123 (Fla. 3d DCA 1999). All the issues allegedly in conflict have been determined by this Court in Rodriguez. The basis for review is gone. There is no conflict, and there was no certification by the Fourth District. This case should be dismissed.

Even if this Court declines to dismiss the entire case, this Court should not address withdrawal or termination of benefits procedures in this case. In order to have an issue addressed by this Court, it must have been properly raised and argued below. See Trushin v. State, 425 So.2d 1126, 1130 (Fla. 1983) (refusing to address issues not raised in the trial court or DCA); Savoie v. State, 422 So.2d 308 (Fla.1982) (This Court "has jurisdiction to consider all issues appropriately raised in the appellate process, as though the case had originally come to this Court on appeal"). This case has always involved only a reduction of charges. The procedure for withdrawal or termination could not have been properly argued to the trial court or to the Fourth DCA.

This Court has made clear that it will not exercise its jurisdiction to address an issue which is not dispositive of the case before it. "This authority to consider issues other than those upon which jurisdiction is based is discretionary with this Court and should be exercised only when these other issues

have been properly briefed and argued and are dispositive of the case." Savoie, 422 So.2d at 312. "While we have the authority to entertain issues ancillary to those in a certified case, . . . we recognize the function of district courts as courts of final jurisdiction and will refrain from using that authority unless those issues affect the outcome of the petition after review of the certified case." Trushin, 425 So.2d at 1130 (citing Bell v. State, 394 So.2d 979 (Fla.1981)). See also Savona v. Prudential Ins. Co. of America, 648 So.2d 705, 707 (Fla. 1995). A decision by this Court on the procedure for withdrawal or termination of benefits will not affect the outcome of the instant case.

Petitioner has (correctly) abandoned the issues argued below in light of this Court's decision in Rodriguez, and is improperly attempting to use this case to obtain an opinion from this Court on issues that are not presented here.

D. EVEN IN A WITHDRAWAL CASE, SUMMARY JUDGMENT DOES NOT REQUIRE ANY PROOF BY THE DEFENDANT.

Even if this Court elects to address the withdrawal issues, Petitioner's argument must still be rejected. In addition to failing to distinguish between a reduction of a claim and a withdrawal of benefits, Petitioner makes no distinction between the burdens of proof imposed on each party, nor between the

proof necessary to avoid summary judgment and that required at trial.

The plaintiff has the burden, as an essential element of his claim, to establish that the bill is reasonable, at the usual, customary charge, necessary, and related to the accident. See Fla. Stat. § 627.736(1); Derius v. Allstate Ind. Co. 723 So.2d 271, 272 ("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 the absence of such proof by the plaintiff, the insurer prevails. An insurer defending against a summary judgment does not have the obligation to disprove the elements of the plaintiff's claim.

Furthermore, the reasonabless, relatedness, and necessity of a bill is virtually always a question of fact. Petitioner asks this Court to impose a procedure whereby the insurer must obtain medical experts to render a report prior to summary judgment, in order to avoid a conclusive presumption that the unmet elements of the claim are actually met. There is simply no support for this procedure, which amounts to an improper reallocation of the burden of proof. In all other cases, parties defending against summary judgment will simply argue that there is a lack of conclusive proof by the Plaintiff, or at

least a fact question, and have their medical experts testify at trial. There is no justification for changing that procedure here.

As a practical matter, Petitioner's argument is bad policy. It would force a race to the court house to see if the carrier could find a medical expert to testify that the bill was excessive before the plaintiff could get a hearing on summary disposition. Since virtually all personal injury protection claims are litigated in County Court, the summary disposition would be pursuant to Small Claims rule 7.135, not Florida Rule of Civil Procedure 1.510. The Small Claims rule does not require that the motion be filed in advance of the hearing. Instead of furthering speedy resolution, Petitioner's proposed procedure would force carriers to incur unnecessary expenses simply to preserve their substantive rights to contest the claim.

Petitioner claims at page 5 of its brief (without citation) that Justice Pariente's concurrence in Rodriguez "recognizes a distinction between eliminating an insurer's ability to defend a claim merely based on its overdue status, and the circumstance where the insurance carrier fails to produce an appropriate report in order to justify its withdrawing of payment at a dispositive hearing." Without citation, it is difficult to

determine which passage of the concurrence Petitioner is referencing, but the concurrence simply does not support the Petitioner's claim. In fact, the concurrence clearly explains that "the purpose of the no-fault scheme does not logically extend to require an insurer to automatically pay for bills for which the insurer is not responsible." Rodriguez, at *5.

Contrary to this mandate, Petitioner attempts to create a forfeiture of the insurer's right to contest the claim based on whether it has a report by a certain time. The only difference between the argument raised in Rodriguez and the argument raised here is the definition of the time frame. The attempt to use the 30 day period as a time limit has already been rejected, and Petitioner's attempt to create a new "summary judgment" time limit should likewise be rejected. At least the statute mentions a 30 day period. Petitioner's new theory, that the report must be obtained by the time of summary judgment, is unsupported by any language in the statute. This new proposed penalty and procedure must be rejected.

CONCLUSION

This Court should approve the decision of the Fourth District Court of Appeal, or should dismiss this case.

Respectfully submitted,

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Tracy Raffles Gunn, Esquire
FOWLER WHITE BOGGS BANKER P.A.
Post Office Box 1438
Tampa, FL 33601
813 228-7411
Florida Bar No.: 984371
Attorneys for Progressive Insurance Companies and Florida Defense Lawyers Association

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Mail to:

MARK TISCHHAUSER, ESQUIRE
3134 North Boulevard
Tampa, FL 33603

DIEGO ASENCIO, Esquire
636 U.S. Highway 1, Suite 115
North Palm Beach, FL 33408

RICHARD A. SHERMAN, Esquire
Richard A. Sherman, P.A.
1777 South Andrews Avenue, Suite 302
Fort Lauderdale, FL 33316

JAMES PETER COOKSEY, Esquire
2601 Broadway, Suite 3
Riviera Beach, Florida 33401

GARY DICKSTEIN, ESQUIRE
ROBERT R. REYNOLDS, IV, ESQUIRE
Dickstein Reynolds & Woods, P.A.
515 N. Falger Drive, Suite 700
West Palm Beach, FL 33401-4324

on January 31, 2002.

_____
Attorney

CERTIFICATE OF COMPLIANCE

I HEREBY CERTIFY that this brief complies with the font requirements of Florida Rule of Appellate Procedure 9.210(a)(2).

Respectfully submitted,

_____
Tracy Raffles Gunn, Esquire
FOWLER WHITE BOGGS BANKER P.A.
Post Office Box 1438
Tampa, FL 33601
813 228-7411
Florida Bar No.: 984371
Attorneys for Progressive Insurance Companies and Florida Defense Lawyers Association

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