IN THE SUPREME COURT OF FLORIDA
IN AND FOR THE STATE OF FLORIDA

MAURICE DERIUS,

Appellee/Petitioner,

v.

SC Case No.: SC01-296
4th DCA Case No.: 4D99-3842

ALLSTATE INDEMNITY COMPANY,

Appellant/Respondent.

PETITIONER'S BRIEF ON THE MERITS

Respectfully Submitted,

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II. STATEMENT OF CASE & FACTS

The necessary facts have already been set forth in the previous briefs.

III. SUMMARY OF THE ARGUMENT

Essentially, the focus of dispute between the Petitioner and Respondent revolves around the holding of this Honorable Court in United Auto. Ins. Co. v. Rodriguez, 26 Fla. L. Weekly S747 (Fla. Nov. 8, 2001). The Respondent contends that Rodriguez , forecloses all issues regarding the application of Fla. Stat 627.736(7)(a) and its medical report requirements and the Petitioner contends that this Court's ruling was merely to state that a medical report was not the only "reasonable proof" an insurer could obtain to defend a claim and that failure to obtain the "reasonable proof" within the 30 day time frame of section 627.736(4)(b) did not obligate payment of the benefits, but exposed a carrier to interest and attorney's fees for being overdue. The Petitioner also disagrees with the Respondent's view that reducing a submitted charge and withholding payment is somehow different than withdrawing payment, a distinction created by the Respondent to avoid the application of Florida Statute section 627.736(7)(a).

III. ARGUMENT

A. THE ARGUMENT OF THE PETITIONER IS NOT NEW, AS THE ISSUE BEFORE THIS COURT IS ESSENTIALLY THE SAME AS THAT REFLECTED IN THE ORIGINAL CERTIFIED QUESTION.

While the Respondent is essentially correct that the focus of the Petitioner's argument has changed, it is not accurate to state that the issue raised is new and was never raised in the lower courts. The issue of when, or if, a medical report is a condition precedent to reducing or refusing to fully pay for medical charges submitted under a PIP insurance policy has always been the issue at hand. The only distinction, which is of little consequence, has been the timing of that requirement. At the time of the underlying summary judgment, the trial court ruled that the insurer's failure to comply with the condition precedent of Florida Statute sec. 627.736(7) within the time frame provided by Florida Statute section 627.736(4)(b) acted as a bar to defending non-payment of the claim.

At the core of this issue, however, has always been the issue of determining when an insurer is obligated to obtain a medical report as a condition precedent to denying payment to a healthcare provider. There is a spectrum of points at which this statutory requirement could arise ranging from the initial 30 day requirement initially sought by the Petitioner to not being required at all, as suggested by the

Respondent To suggest that because the Petitioner's initial argument focus was at the earliest part of the spectrum, which has admittedly been disapproved by this Honorable Court in Rodriguez, is a failure to raise the overall issue is disingenuous. Even the certified question to the District Court of Appeal belies the fact that from the very inception of this issue, the parties and the trial court sought a determination of the circumstances associated with the medical report requirement under Fla. Stat. 627.736(7)(a), irrespective of the 30 day time frame of Florida Statute section 627.736(4)(b). The certified question, as reflected in the Respondent's Brief reads:

> " Must an insurance company, who seeks to reduce bills for medical treatment, pursant to Section 627.736(1)(a) , first obtain a report from a physician licensed under the same chapter as the treating physician stating that the bills for treatment are not reasonable, pursuant to Section 627.736(7)(a)?"

Even the briefest review of the language of the certified question shows that the time frame of 30 days was an ancillary component of the question placed before the District Court of Appeal. As stated previously, the basis of the issue has always been predicated upon the ruling in United Auto. Ins. Co. v. Viles, 726 So. 2d 320 (Fla. 3d DCA 1998), which was, in fact, even cited by the trial counsel for the Respondent in the summary judgment hearing.

B. IT IS THE POSITION OF THE PETITIONER THAT THE RESPONDENT EXTENDS THE RULING IN THE RODRIGUEZ

CASE IN A MANNER THAT WOULD NEGATE THE PROVISIONS OF FLORIDA STATUTE 627.736(7)(A).

The Respondent contends the Rodriguez decision recently issued by this Honorable Court extends so far as to eliminate any requirement by an insurer to obtain a report from a qualified physician when reducing or denying full payment to a healthcare provider. In contrast, it is the Petitioner's reading of Rodriguez, that this Honorable Court ruled that a medical report was not the only type of reasonable proof necessary to comply with Florida Statute section 627.736(4)(b) and that failure to obtain such a report within 30 days did not result in a "sudden death" circumstance in which the insurer was obligated to pay benefits at issue. If the Petitioner is correct, as to the this Honorable Court's intentions in Rodriguez, then the question posed by the trial court referenced above is still at issue and requires resolution by this Honorable Court.

It is admittedly difficult for the Petitioner to accept the Respondent's view of the ruling in Rodriguez as it would effectively negate the language of section 627.736(7)(a) and it is well established that the courts should not interpret the language of a statute to a nullity. It defies common sense that the Legislature would establish what is essentially a medical oversight provision under Florida Statute section 627.736(7)(a), and intend that an insurer could satisfy this requirement at

any time, even after suit has been filed declaring a breach of the policy, after a dispositive hearing or even after a trial. If one takes the furthest extension of the Respondent's view that no time frame is imposed upon an insurer under section 627.736(7)(a), a point admittedly made to illustrate absurdity, an insurer could seek relief from judgment against it by obtaining a report after trial claiming new evidence or that, since there was no time frame required it was able to cure the defect of not having the report.

If one accepts the proposition that a medical report is needed to deny payment to a physician based upon the medical charges being unreasonable, unnecessary or unrelated, as stated in the common language of the statute itself, then the most obvious point at which an insurer would be expected to have such a report would be prior to the initiation of suit by the insured on that issue. Prior to that point, the insurer would be able to effectively "cure" the defect by securing the appropriate. This is certainly consistent with the ruling in Rodriguez, which clearly expressed this Honorable Court's concern that its was unfair to burden insurers with payment of medical bills merely because they could not obtain a medical report within 30 days. IN contrast, allowing, as suggested by the Respondent, the insurer to obtain a report *after* suit has been filed essentially permits an insurance company to defy the statutory requirements of section 627.736(7)(a), forcing the

insured to retain counsel at its expense to challenge a denial of benefits, only to then be confronted with a newly obtained report that cures the very defect that forced suit. It is clearly not the purpose of the No-Fault Act to create an environment where Florida insured's purchase insurance policies under the promise of speedy and prompt handling of claims, only to be presented with recalcitrant insurers who evaluate the necessity, reasonableness and relationship of medical care *after they have been sued for non-payment.* It is the Petitioner's position that this is most logical point by which an insurer would be required to have obtained a written report sufficient to satisfy the requirements of Fla. Stat. 627.736(7)(a).

The absolute latest point in time that such a report should be permitted is at a dispositive hearing such as a summary judgment, directed verdict motion or final hearing. It appears that the Respondent has confused the Petitioner's statements that this was the latest practical time for compliance not the most logical or appropriate. The flaw in allowing the securing of a report at such a late point in a dispute over the reasonableness, necessity or relationship of medical charges is that it allows an insurer to reverse engineer reasons for non-payment rather than conduct its investigation in a timely fashion. The facts in the case at bar are an excellent example of an insurer reverse engineering its defenses, not to ensure an timely and proper assessment of its obligation to protect and indemnify its insured, but to

construct defenses to avoid payment. The charges in the case at bar were submitted for payment from 1994 through February 1995. The first report from a physician was obtained over three years later long after suit had been filed by the insured challenging Allstate's reasons for denial of payment. Along these same lines, Allstate, the Respondent, continues to assert that the defense in this case was merely a "reduction" of the requested benefits, whereas the letter from Dr. Ziede, Allstate's expert, clearly indicates that the charges at issue were now being challenged by Dr. Ziede as to the necessity of the services. Literally, years after suit was filed over Allstate's contention that the charges were not reasonably priced, the basis for the denial changes to include that the services weren't necessary, a new issue for the insured to contend with in securing payment of the charges.

C. THE RESPONDENT'S ATTEMPT TO ARTIFICIALLY DISTINGUISH BETWEEN WITHDRAWING BENEFITS AND REDUCING OR REFUSING PAYMENT IS A SEMANTIC DISTINCTION WITHOUT A DIFFERENCE.

The Respondent seeks to convince this court that, "reductions" of benefits are not a withdrawal of benefits so as to invoke the requirements of Florida Statute section 627.736(7)(a). It is clear that Allstate seeks refuge in semantics as Allstate contends that it only "reduced" the value of the charges submitted when in reality the some of the charges at issue were reduced by 100% and no-payment was

made. As illustrated below, even a normal "reduced" payment is a withdrawal as defined by Fla. Stat 627.736(7)(a) because the obligation to pay the benefits attaches upon receipt of the bill.. It defies common sense, and requires linguistic gymnastics, to suggest that reducing a payment obligation is not a withdrawal of payment, especially when exemplified by a "reduction of payment" to nothing. Even the trial court recognized the lack of distinction when confronted with the Respondent's definitional argument that reasonable *expenses* were different than the reasonable *amount* of expenses when it stated:

"THE COURT: Somehow there's a difference there?"

In order to understand the error in the Respondent's a view, one must look to the terms of the No-Fault Act and the process and protections that were created within the statute. First, it is clear that benefits are due, not upon proof of reasonableness or relatedness, but as the losses accrue and proof of that loss is submitted to the insurer. Florida Statute section 627.736(4) states as follows:

> " (4) BENEFITS; WHEN DUE. - Benefits due from an insurer under ss. 627-730-627.7405 shall be primary .... (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred...."

In construing a statutory provision the court's are compelled to give ordinary ,meaning to the words used by the Legislature. The use of the word "accrue" as

defined in Barron's Law Dictionary:

> " ACCRUE generally, to accumulate, to happen, to come into fact or existence..."

With this in mind, it is clear that the Legislature intended that a PIP insurance carrier become obligated to pay for PIP benefits, upon submission of a bill or other proof of loss, and not upon later investigation determining whether it is compensable. Instead, Florida Statute section 627.736(4)(b) provides what is essentially a thirty (30) day "grace period" through which an insurer is provided the opportunity to obtain reasonable proof to show that the insurer is not responsible for payment in order avoid the benefits being declared overdue. As set forth in Rodriguez, the type of proof available to satisfy the require of Florida Statute 627.736(4)(b) is not limited to a medical report, but is more broadly construed to be whatever is ultimately considered "reasonable" proof. The important distinction under Florida Statute 627.736(4) (b) is that an insurer may obtain any reasonable proof in order to show that it is *not responsible for payment.* This language is clearly intended to encompass the myriad of reasons for which an insurer may not be responsible for payment ranging from lack of coverage, to unrelated care, to fraud or mistake.

In order to avoid the circumstance that an insurer could become

inadvertently obligated to pay for unrelated benefits, or subjected to fraudulent or mis-representative claims, the Florida Legislature had the foresight to provide a number of safety mechanisms in the No-Fault Act. For example, Florida Statute section 627.736(5)(a) specifically limits healthcare providers to submitting reasonable charges and section 627.736(6)(b) entitles an insurer to demand that such providers swear under penalty of perjury that the charges submitted are in fact reasonable, which exposes any healthcare provider to disciplinary action and criminal prosecution if the charges are not reasonable. Florida Statute section 627.736(7) allows an insurer to secure an independent examination of the injured party, and eliminates reliance on the treating physicians for evaluation of the injured persons condition. Florida Statute section 627.736(5)(d) requires that charges are submitted with CPT and HCFA standards to ensure uniformity and minimize investigative efforts by the carrier, while section 627.736(6)(b) allows an insurer to delay payment until requested information is provided, which extends the investigative window until compliance is had. Even section 627.736(7)(b) obligates an insured to full medical record disclosure if a copy of the IME report is requested, forcing a waiver of medical privilege. These protections are in addition to those traditionally provided by insurance policy language such as cooperation obligations, examination sunder oath, etc, all under penalty of forfeiture of

coverage. These protections virtually eliminate the opportunity for an insurer to pay a submitted charge that is unrelated or by being mislead unless it is by its own carelessness. Even then, the latest revision of the No-Fault Act, modifed section 627.736(4) to allow an insurer to recover charges already paid and any intentional misrepresentations, if not thwarted by the investigative protections, are easily documented for criminal fraud , perjury , or licensure discipline.

Florida Statute section 627.736(7)(a) that addresses the specific requirement that a report from a similarly licensed physician is obtained prior to withdrawing payment of a treating physician. The relevant part of Florida Statute section 627.736(7)(a) reads as follows:

> " An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by 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 the treatment is not reasonable, necessary or related."

Again the language used is instructive to understand the Legislature's intent, as the word "payment" is used in a manner indicating an existing obligation, as opposed terms such a "obligation to pay" or "payable." This is also consistent with the concepts set forth in Fla. Stat 627.736(4) that benefits are due upon receipt, but provided a 30 day grace period for investigation. It is also important to

note the specific references to the issues of reasonableness, necessity or relationship of medical charges and the limitation of payments to physicians and not issues such as fraud, coverage, wages, etc. In essence, the focus of the language in section 627.736(7)(a) is to avoid the very problem so endemic to the healthcare industry where medical issues are not determined by treating physicians, but often by lay employees, or computers, placing quality of medical care below the convenience of administration. The Florida No-Fault Act, however, was intended to allow insureds obtain the best medical care available for their injuries, for a reasonable value, as it was intended to supplant the tortfeasor's obligation for those same expenses. The intent of the Florida No-Fault Act was to provide speedy swift payment of benefits without regard to fault as a means of eliminating court congestion and litigiousness. Lasky One must surely believe that the Legislature did not intend to condemn injured people to a substandard medical care system or merely to exchange a third party tortfeasor for a more formidable and wealthy first party insurance company as a litigant.

In contrast, the Respondent asks this Honorable Court to construe the Florida No-Fault Act in a manner entirely inconsistent with both the language and the intent of the Legislature, but clearly convenient to the Respondent's argument. The Respondent suggests that the term "withdraw payment" implies a withdrawal

of treatment authorization for future benefits. It is easy to understand the lure of such an interpretation as this is a frequent issue in health insurance policies. However, nowhere within the Florida No-Fault Act is the concept of pre-authorization of treatment provided as it the focus of the Act has been to afford insured's the opportunity elect both the nature and manner of their care, as long as it is reasonable, necessary and related. In fact, Florida has long recognized that causes of action based upon denial of future PIP benefits do not mature until an actual breach of the PIP policy has occurred. Peachtree More importantly, none of the other areas of insurance, such as health insurance, have the constitutional implications attendant to PIP benefits and the Florida No-Fault Scheme.

A second argument commonly raised by the insurance industry is to decry the inapplicability of language of section 627.737(7)(a) to other healthcare claims such as non-physician diagnostic facilities, coverage or fraud claims, or unlicensed healthcare professionals and a means of diffusing the obligation of obtaining a medical report. As stated above, the fallacy to this argument is reflected in the language of the statute itself which limits its application to challenging the services rendered by a "physician" as opposed to healthcare provider in general. This consistent with the additional requirement of licensure equality as many, many healthcare services are rendered, such as diagnostics, medical appliances, and

ancillary health services which would be outside the scope of the protections of section 627.736(7)(a) to insure that the treating physicians care is not micro or lay managed, but subjected to an effective "peer" review. This argument is often accentuated by claims that such assessments of the reasonableness of the charges, the necessity of the care, or the relationship of the care to a covered event, is not within the purview of physician's expertise. Of course, this argument is easily dispelled by the fact that Dr. Ziede's letter was offered by Allstate for the that very purpose in the case at bar.

The final argument posited is that the Florida Statute section 627.736(7)(a) does not come into play when all that is challenged by an insurer is the reasonable value of the charges submitted. To accept such an argument would require this Honorable Court to judicially excise the word "reasonable" from the actual language of Florida Statute section 627.736(7)(a) as it specifically references the applicability of that section to challenges based upon the *reasonableness*, necessity or relationship of the benefits sought by a physician.

D. THE "REPORT" SUBMITTED BY ALLSTATE WAS INSUFFICIENT TO COMPLY WITH FLORIDA STATUTE SECTION 627.736(7)(A)

As stated above Florida Statute section 627.736(7)(a) requires a written

report of a comparable physician prior to denying payment of a treating physician's billings on the basis of their reasonable value, the necessity of the services, or their relationship to the loss at issue. Clearly, the letter from Dr. Ziede was secured long after that point and well into actual litigation. Along these same lines, Florida Statute section 627.736(7)(a) contemplates a report that is the basis for the denial of payment. A careful reading of the letter from Dr. Ziede clearly indicates that it is not the basis of the decision to deny payment but is merely *supportive* of the long standing decision previously made. This letter, by its nature is no different than securing a supportive deposition statement of a physician after suit has been filed, again, a circumstance which would defeat the purpose of section 627.736(7)(a).

Further, the document at issue could not have properly considered by the trial court. Although an affidavit was submitted attaching the purported letter from Dr. Ziede, the affidavit was not a from a record custodian of the Respondent, nor of Dr. Ziede, but of Allstate's counsel. The Florida Bar rules have long prohibited counsel from testifying as witnesses in their own cases as to material facts or issues, for the obvious reasons that it allows self serving testimony or exposes counsel to a compromising position in a court proceeding.

E. THE RESPONDENT'S ATTEMPT TO DISSUADE THIS COURT FROM ADDRESSING THE ISSUES IN THIS CASE BASED UPON LACK OF A CAUSE OF ACTION, WAS NEVER RAISED, EVEN AT THE TRIAL COURT LEVEL.

The Respondent seeks to raise the issue of the value of the damages as a means of inducing this Honorable Court to deny relief to the Petitioner. The record is clear that the issue before this Court is the very narrow one defined by the certified question and ruled upon by the District Court of Appeal. If the damages issue warranted appellate review, the Respondent could have filed a cross-appeal, or its own Petition for Discretionary Review, seeking same. Absent this, this issue is nothing more than an attempt to distract this Honorable Court from a determination on the very important merits and legal issues of this cause by suggesting the monetary claim at hand is deminimus.

IV. CONCLUSION

With the above in mind, the Petitioner respectfully asks this Honorable Court to revisit the ruling in Rodriguez, in order to provide more clear direction as to the application of Florida Statute section 627.736(7)(a) and the medical report obligation, affirming the trial court's determination that report untimely obtained is insufficient to permit an insurer to justify withholding benefits for medical services

rendered to an insured and such other relief as this Honorable Court deems necessary to enforce the proper effect of the Florida No-Fault Act for the benefit of Florida insureds.

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