SUPREME COURT OF THE STATE OF FLORIDA
Case No.: SC02-285
District Court of Appeal for the Fifth District Case No.: 5D00-3064

DAN RAY WARREN, ET AL.

Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Respondent.
_____/

RESPONDENT'S ANSWER BRIEF

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PRELIMINARY STATEMENT

Throughout this Brief, PETITIONERS, DAN RAY WARREN and JACK ROTSTEIN, M.D., shall be referred to as "PETITIONERS," "PETITIONER WARREN," or "PETITIONER ROTSTEIN." Respondent, STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, shall be referred to as "RESPONDENT."

STATEMENT OF THE CASE AND FACTS

Because PETITIONERS' statement of the facts is incomplete and includes statements which are not supported by the trial court record, RESPONDENT elects to provide a summary of the case and facts.

PETITIONER WARREN filed a Complaint against RESPONDENT seeking recovery of no-fault benefits in accordance with §627.736, Fla. Stat. (1999). (See Exhibit "A" of Appendix to Respondent's Answer Brief.) The Complaint alleged that PETITIONER WARREN was injured in a motor vehicle accident which occurred on March 22, 1999 and that he thereafter sought treatment from PETITIONER ROTSTEIN for his injuries. (See Exhibit "A" of Appendix to Respondent's Answer Brief.) At the time of the motor vehicle accident, PETITIONER WARREN was insured under a policy of insurance issued by RESPONDENT.

PETITIONER WARREN received treatment from PETITIONER ROTSTEIN on the following dates: May 27, 1999, June 16, 1999, and July 6, 1999. (See Exhibit "A" of Appendix to Respondent's Answer Brief.) Upon initiating treatment, PETITIONER ROTSTEIN did not submit a notice of initiation of treatment to RESPONDENT. On August 9, 1999, PETITIONER ROTSTEIN submitted a request for payment for these three dates of service to RESPONDENT. It was undisputed that PETITIONER ROTSTEIN's request for payment was not submitted to the RESPONDENT within 30 days following the dates of treatment as required by §627.736(5)(b), Fla. Stat. (1999).

RESPONDENT denied payment of these bills because they were not timely submitted.

The trial court issued an order on February 9, 2000 adding PETITIONER ROTSTEIN as a plaintiff in the litigation.

RESPONDENT filed Defendant's Motion for Summary Judgment and Memorandum in Support on or about May 12, 2000 in which it argued that PETITIONERS' claim must be dismissed because PETITIONER ROTSTEIN failed to comply with §627.736(5)(b), Fla. Stat. (1999). (See Exhibit "B" of Appendix to Respondent's Answer Brief.) PETITIONERS likewise filed Plaintiff's Motion for Summary Judgment and Memorandum in Support in which they argued that PETITIONER ROTSTEIN should not be required to comply with the 30-day billing requirement because §627.736(5)(b), Fla. Stat. (1999) violated the equal protection and due process clauses of the federal and Florida constitutions and violated PETITIONERS' constitutionally-protected right of access to the courts. (See Exhibit "C" of Appendix to Respondent's Answer Brief.)

By order dated June 20, 2000, the trial court granted PETITIONERS' motion and denied RESPONDENT's motion. (See Exhibit "D" of Appendix to Respondent's Answer Brief.) Finding that the 30-day billing provision was not reasonably related to a legitimate legislative objective, the trial court held that §627.736(5)(b), Fla. Stat. (1999) "is unconstitutional as violative of the Plaintiffs' rights of due process, equal protection, and access to courts."

[1] (See Exhibit "D" of Appendix to Respondent's Answer Brief.)

The trial court entered the Final Judgment on September 18, 2000. (See Exhibit "E" of Appendix to Respondent's Answer Brief.) In the Final Judgment, the trial court certified the following question as a matter of great public importance:

> Does Fla. Statutes Section 627.736(5)(b) violate the due process, equal access to courts, and/or equal protection rights of health care providers that are not hospitals or ambulance companies?

(See Exhibit "E" of Appendix to Respondent's Answer Brief.)

RESPONDENT filed a Notice of Appeal in the Florida District Court of Appeal for the Fifth District and requested the Florida District Court of Appeal for the Fifth District accept jurisdiction, which it did. On February 1, 2002, the Florida District Court of Appeal for the Fifth District issued an opinion in which it held that §627.736(5)(b), Fla. Stat. (1999) did not violate the rights of due process, equal protection, and access to the courts as set forth in the federal and Florida constitutions. (See Exhibit "F" of Appendix to Respondent's Answer Brief.) The Florida District Court of Appeal for the Fifth District reversed the trial court's granting of summary judgment in favor of PETITIONERS and remanded the matter to the trial court with the direction that summary judgment should be entered in favor of RESPONDENT. (See Exhibit

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[1] PETITIONERS claimed that the trial court found that §627.736(5)(b), Fla. Stat. (1999) violated the equal protection clause of the Florida Constitution "because the statute does not require any reasonable proof that the charges are not reasonable, necessary or related." (See p. 2 of Petitioner's Initial Brief.) The trial court never made any such finding.

"F" of Appendix to Respondent's Answer Brief.)

Thereafter, PETITIONERS timely sought review by this Court.

SUMMARY OF THE ARGUMENT

The Florida District Court of Appeal for the Fifth District did not commit error by holding that §627.736(5)(b), Fla. Stat. (1999) does not violate the federal and Florida constitutions. Because receiving insurance benefits directly from an insurance company does not involve a fundamental right, and because PETITIONER ROTSTEIN is not part of a suspect class, the standard applied for determining whether the statute violates PETITIONER ROTSTEIN's right to equal protection is the "rational basis" test. Under this standard, a court should find a statute constitutional if the regulatory classification bears some rational relationship to a legitimate state purpose.

There is a rational legislative purpose for requiring medical providers to submit their bills to insurance companies within 30 or 60 days from the date services were rendered and exempting hospital emergency departments and ambulance services from this billing requirement. The services provided by these medical professionals are inherently different. Treatment rendered by medical providers is frequently ongoing and rendered over long periods of time. It is necessary for an insurance company to be made aware of this type of treatment as early as possible so that it can evaluate whether the treatment is subject to payment. If an insurance company is advised of the treatment long after it is rendered, the insurance company would be deprived of the opportunity to seek a timely medical examination of the insured to determine whether the treatment rendered was reasonable, necessary, and related to the

motor vehicle accident at or near the time the services were actually being provided.

Conversely, services provided in hospital emergency departments and by ambulance services, by their very nature, are not ongoing and are usually provided only once immediately following a motor vehicle accident. It would not be necessary for an insurance company to receive bills from hospital emergency room departments and ambulance services within 30 or 60 days from the date of the rendition of treatment, as it is usually a simple matter to determine that these services were reasonable, necessary, and related to a specific automobile accident.

The distinction in the statute is not between different types of medical providers, but rather between medical providers who render services on an emergency basis and medical providers who render on-going treatment. The statute not only exempts emergency room departments and ambulance services, but also medical providers who render emergency services.

The test to be used in determining whether a statute violates the due process clause is similar to the test for determining whether a statute violates the equal protection clause. A statute will not violate the due process clause of the federal and Florida constitutions if it bears a reasonable relation to a permissible legislative objective and is not discriminatory, arbitrary, or oppresive.

In the legislative history of the 1998 amendment to §627.736, Fla. Stat. (1999), the Florida Legislature enumerated the reasons for imposing the billing requirement, which are as follows: 1) providing the insurance company notice

as early as possible so that it can evaluate whether the claim is reasonable, necessary, and related to the motor vehicle accident, 2) controlling the costs for insurance premiums which benefits the general public, and 3) curtailing the practice of bulk billing which makes it difficult for insurance companies to evaluate whether any particular treatment is reasonable, necessary, and related to the motor vehicle accident.

For these reasons, the imposition of the billing requirement is reasonably related to legitimate legislative purposes and the statute is not discriminatory, arbitratory, or oppressive. Therefore, the Florida District Court of Appeal for the Fifth District did not commit error by holding that §627.736(5)(b), Fla. Stat. (1999) does not violate PETITIONER ROTSTEIN's right to due process.

PETITIONERS' claim that the 30/60 day billing requirement violates the due process clause because it interferes with an insured's ability to obtain competent care or otherwise affects the quality of the insured's care is without foundation. The billing requirements apply equally to all medical providers; and therefore, an insured is free to seek care from the medical provider of his or her choosing.

The requirement that PETITIONER ROTSTEIN submit his statement of charges within 30 or 60 days of treatment does not abolish or unreasonably restrict his right to access the courts. Rather, it imposes either a reasonable restriction upon the filing of a claim or is a condition precedent to filing a claim. Florida courts have consistently upheld and enforced statutes that impose reasonable restrictions upon the filing of a claim or that require the compliance

with conditions precedent before filing the claim.

PETITIONERS' reliance upon Mutual Fire Insurance Company v. Pinnacle Medical, Inc., 753 So. 2d 55 (Fla. 1999) is misplaced in that the issue in Pinnacle Medical, Inc. was whether medical providers could be compelled to attend binding arbitration, thereby denying them access to the courts altogether. Unlike this arbitration provision, the 30/60 day billing requirement does not abolish or deny access to the courts.

PETITIONERS' claim that the billing requirements set forth in §627.736(5)(b), Fla. Stat. (1999) violate PETITIONER ROTSTEIN's right of access to the courts on the ground that it conflicts with §95.11(2)(b), Fla. Stat. (1999) is without merit. The five year statute of limitations on a contract action as provided in §95.11(2)(b), Fla. Stat. (1999) does not nullify or conflict with the billing requirements of §627.736(5)(b), Fla. Stat. (1999). If a medical provider such as PETITIONER ROTSTEIN believes that an insurance company had wrongfully denied payment of his bills and he submitted his bills to RESPONDENT in accordance with §627.736(5)(b), Fla. Stat. (1999), the medical provider would have five years following the denial of the claim to bring a lawsuit pursuant to §95.11(2)(b), Fla. Stat. (1999).

Because §627.736(5)(b), Fla. Stat. (1999) does not violate the federal and Florida constitutions, the Florida District Court of Appeal for the Fifth District did not commit error by reversing the trial court's granting of summary judgment in favor of PETITIONERS and remanding the matter to the trial court with directions to enter summary judgment in favor of RESPONDENT.

Because it is undisputed that PETITIONER ROTSTEIN did not submit the bills at issue to RESPONDENT within 30 days of treatment in compliance with §627.736(5)(b), Fla. Stat. (1999), RESPONDENT is not legally required to remit payment for those bills and PETITIONER ROTSTEIN is not entitled to receive payment for those bills, either from RESPONDENT or PETITIONER WARREN.

Accordingly, RESPONDENT respectfully requests that this Court affirm the decision of the Third District Court of Appeal for the Fifth District.

ARGUMENT

I. THE FLORIDA DISTRICT COURT OF APPEAL FOR THE FIFTH DISTRICT DID NOT COMMIT ERROR BY RULING THAT SECTION 627.736(5)(b), FLA. STAT. (1999) DID NOT VIOLATE PETITIONERS' CONSTITUTIONAL RIGHT TO EQUAL PROTECTION, DUE PROCESS, AND ACCESS TO COURTS.

A. Section 627.736(5)(b), Fla. Stat. (1999) does not violate PETITIONER ROTSTEIN or PETITIONER WARREN the right to equal protection.

When a trial court rules that a Florida statute is unconstitutional, the decision of the trial court is reviewed by the de novo standard because it presents a pure issue of law. State of Florida, Department of Insurance v. Keys Title and Abstract Co., Inc., 741 So. 2d 599, 601 (Fla. 1st DCA 1999). Although the appellate court is generally required to defer to the judgment of the trial court in an appeal, this is not the case when the trial court has declared a statute unconstitutional. Id. Rather, "the reviewing court must begin the process of appellate review with the presumption that the statute is valid." Id. "Any legislative enactment carries a strong presumption of constitutionality, including a rebuttable presumption of the existence of necessary factual support in its provisions." State v. Bales, 343 So. 2d 9, 11 (Fla. 1977). "If any state of facts, known or to be assumed, justify the law, the court's power of inquiry ends." Id.

The Florida Constitution provides that persons must be afforded equal protection of the law. Article 1, section 2 of the Florida Constitution provides as follows:

> All natural persons, female and male alike, are equal before the law and have inalienable rights, among which are the right to enjoy and defend life and liberty, to pursue happiness, to be rewarded for industry, and to acquire, possess, and protect property; except that the ownership, inheritance, disposition and possession of real property by aliens ineligible for citizenship may be regulated or prohibited by law. No person shall be deprived of any right because of race, religion, national origin, or physical disability.

This constitutional requirement does not deprive the Florida Legislature of the ability to distinguish one class of persons from another in its laws. Keys Title and Abstract Co., Inc., 741 So. 2d at 601. In Florida League of Cities, Inc. v. Department of Environmental Regulation, 603 So. 2d 1363, 1368 (Fla. 1st DCA 1992), the First District Court of Appeal explained:

> . . . [T]he constitutional requirement of equal protection of the laws does not inhibit the legislative power in securing the health, safety, morals, and general welfare of the public, and **a classification enacted by the legislature for such purposes will not be annulled by the courts unless it is wholly without a reasonable or practical basis, and therefore purely arbitrary**. (emphasis added.)

Thus, "[t]he question the [appellate] court must answer is whether the distinction is one that is proper, given the purpose of the statute." Id. at 1368. "[S]tatutory classifications that treat one person or group differently than others must appear to be based at a minimum on a rational distinction having a just and reasonable relation to a legitimate state objective." Palm Harbor Special Fire Control District v. Kelly, 516 So. 2d 249, 251 (Fla. 1987).

Before reviewing whether a statute violates the equal protection clause of

the Florida Constitution, the appellate court must determine the appropriate level of judicial scrutiny to be applied to the state regulation under attack. The Florida High School Activities Association, Inc. v. Thomas, 434 So. 2d 306, 308 (Fla. 1983). Unless the statute involves a fundamental right or suspect classification, the rational relationship test is applied. Id. See also Bales, 343 So. 2d at 11. A fundamental right is "a right which has its source in, and is explicitly guaranteed by, the federal and/or Florida constitutions." State v. T.M., A.N. and D.N., 761 So. 2d 1140, 1145 n. 2 (Fla. 2nd DCA 2000). "A 'suspect class' is any group that has been the traditional target of irrational, unfair, and unlawful discrimination." Coy v. Florida Birth-Related Neurological Injury Compensation, 595 So. 2d 943, 945 (Fla. 1992).

This case does not involve either a suspect class or a fundamental right. The Supreme Court of Florida held in Coy that physicians, such as PETITIONER ROTSTEIN, do not fit within the definition of a suspect class. Id. Additionally, receiving payment of benefits from an insurance company is not a fundamental right because it is not guaranteed by the federal or Florida Constitutions. T.M., A.N. and D.N., 761 So. 2d at 1145, n. 2. Accordingly, §627.736(5)(b), Fla. Stat. (1999) must be reviewed under the rational basis test.

"Under a 'rational basis' standard of review, a court should inquire only whether it is conceivable that the regulatory classification bears some rational relationship to a legitimate state purpose." Thomas, 434 So. 2d at 308. If the District Court of Appeal "can conceive of a rational basis it must uphold the statute." Jackson v. State, 729 So. 2d 947, 950 (Fla. 1st DCA 1998).

The burden is on the party challenging the statute or regulation to show that there is no conceivable factual predicate which would rationally support the classification under attack. Where the challenging party fails to meet this difficult burden, the statute or regulation must be sustained. Thomas, 434 So. 2d at 308.

The trial court in this case concluded that §627.736(5)(b), Fla. Stat. (1999) violated the equal protection clause of the Florida Constitution because it distinguished between health care providers, like PETITIONER ROTSTEIN, and hospitals and ambulance companies. This provision, which was added to the statute by amendment in 1998, provides, in relevant part:

> With respect to any treatment or service, other than medical services billed by a hospital for services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or service rendered more than 30 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 60 days before the postmark date of the statement . . . For emergency services and care as defined in s. 395.002 rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph.

Because the proper standard of review of the constitutionality of

§627.736(5)(b), Fla. Stat. (1999) is the rational basis test, §627.736(5)(b), Fla. Stat. (1999) will not violate the equal protection clause of the Florida Constitution as long as the distinction in the statute between medical providers and hospital emergency departments and ambulance providers "bears some rational relationship to a legitimate state purpose." Thomas, 434 So. 2d at 308. The Florida Legislature had a legitimate state purpose for distinguishing between medical providers and hospital emergency departments and ambulance providers. This legislative purpose is grounded in the underlying rationale for the billing requirement.

Sections 627.736(1) and (4)(b), Fla. Stat. (1999) allow insurance companies just 30 days from receipt of the claim to pay all reasonable expenses for necessary treatment related to a motor vehicle accident. In the event the insurance company fails to comply with this requirement, the insurance company may be subject to interest payments on all overdue bills as well as attorney's fees and costs. See 627.736(2)(b), Fla. Stat. (1999). Because the insurance company has only 30 days to determine whether the insured's treatment and medical charges are reasonable, necessary, and related to the motor vehicle accident, the Florida Legislature has found that it is critical for an insurance company to begin investigating the insured's claim as early as possible.

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[2] Additionally, the Statewide Grand Jury investigating insurance fraud relating to personal injury protection insurance recognized the need for insurers to

The House of Representative's Bill Research & Economic Impact Statement, which was prepared to evaluate the effects of the proposed amendment to §627.736, Fla. Stat., explained the Legislature's rationale for the 30-day requirement as follows:

> The result of the 30-day billing requirement is that insurers would be aware of the commencement of treatment and would be in a better position to assure that treatment is reasonable, related to the motor vehicle accident, or necessary.

(See Exhibit "G" of the Appendix to Respondent's Answer Brief.)

The Florida Senate, like the Florida House of Representatives, recognized that insurance companies must be made aware of their insureds' initiation of treatment. The Senate Staff Analysis and Economic Impact Statement states as follows:

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review and evaluate claims to determine whether claims are fraudulent. In that regard, the Statewide Grand Jury recommended that insurers are given an additional 30 days to pay personal injury protection claims to give insurers more opportunity to identify and deny fraudulent claims. See Report on Insurance Fraud Related to Personal Injury Protection, Statewide Grand Jury Report, Case No. 95, 746 (2000).

> The result of both the 30-day and 60-day billing requirements, is that insurers would be aware of the commencement of treatment and would be in a better position to assure that treatment is reasonable, related to the motor vehicle accident, or necessary.

(See Exhibit "G" of the Appendix to Respondent's Answer Brief.)

There is a rational legislative purpose for imposing the 30/60 day billing requirement upon medical providers but not hospital emergency departments and ambulance services. Medical providers frequently provide ongoing medical treatment which involves regular office visits for chiropractic treatment, physical therapy, orthopedic care, etc. In order to determine whether the treatment is reasonable, necessary, and related to the motor vehicle accident, an insurance company must be advised of this treatment as early as possible so that it can evaluate whether the treatment is appropriate and, ultimately, whether payment for the treatment is required in accordance with §627.736, Fla. Stat. (1999). If there is no deadline within which medical providers must submit their bills to the insurance company, an insured can undergo treatment for weeks or months before the insurance company has an opportunity to evaluate the appropriateness of the treatment. By the time the insurance company receives the bills from the medical providers, it may be impossible for the insurance company to determine whether the treatment provided was necessary if that treatment was rendered months prior to the submission of the claim. The requirement that medical providers submit their statements of charges to the insurance company within 30 or 60 days of treatment ensures that the insurance company is able to conduct a proper evaluation of the claims at or near the time

the treatment is rendered.

Section 627.736, Fla. Stat. (1999) does not contain any provision requiring a medical provider to provide notification to an insurance company when the insured begins treatment. Without the billing requirement, an insured can receive treatment for weeks or months without the insurance company being aware that the insured is undergoing treatment.

Moreover, the 30/60 day billing requirement benefits an insured. If the statute does not require medical providers to submit the statements of charges within 30 or 60 days, the insured may undergo expensive, continuous, unnecessary treatment for months. When the charges are finally submitted to the insurance company, the insured may later be advised after the company's investigation that the treatment was not reasonable, necessary, or related to the motor vehicle accident; and therefore not covered under the insurance policy. If the insured is notified promptly of the insurance company's decision that the treatment being rendered is not reasonable, related, or necessary, the insured may choose not to undergo more treatment or elect some other form of treatment to minimize his or her own financial exposure for those medical charges. The insured loses that option once the treatment is rendered and the charges are incurred. The longer the provider waits to submit the bills, the greater the insured's potential financial exposure for payment of treatment which is not covered under the insured's policy.[3]

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[3] If an insured is not timely notified that that treatment he or she is receiving is not related to a motor vehicle accident, the insured may not be able to submit

Services provided in a hospital emergency department or by an ambulance service are inherently different from treatment provided by medical providers. These services are usually provided only once immediately following the motor vehicle accident. Unlike ongoing medical and chiropractic treatment, it is a relatively straightforward process to determine whether services provided by an ambulance company or a hospital emergency department are necessary and related to the motor vehicle accident. By the very nature of these services, the insurance company must do less to evaluate whether the services are reasonable, necessary, and related to the motor vehicle accident. Therefore, it is not as vital for the insurance companies to receive these bills within 30 or 60 days of the rendition of the services.

Furthermore, it is not feasible to require hospitals and ambulance companies to submit their claims within 30 or 60 days, because they frequently do not have the necessary insurance information which would enable them to file these claims. Unlike services rendered in hospitals or by ambulance companies, treatment provided by a private physician is planned. The insureds have an opportunity to gather their insurance information and provide it to the medical provider prior to or at the time of the first appointment. Conversely, hospital emergency departments and ambulance companies rarely treat patients by appointment. They frequently render services immediately following the

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the bills for the treatment to his or her health insurance company. Health insurance companies also have time requirements for the submission of medical bills.

motor vehicle accident and the insureds often have either not brought their insurance information with them or are unable to give the information due to the nature of their injuries. It may take days or weeks for the hospitals and ambulance companies to obtain insurance information from the insureds so that they can file the claim. Requiring hospitals and ambulance companies to submit their bills within 30 or 60 days would not even be feasible in many cases.

PETITIONERS argue that the statute is unconstitutional because it "improperly discriminates between two classes of similarly situated litigants – doctors and ambulances and hospitals." (See p. 6 of Petitioner's Initial Brief.) The distinction in the statute is not between different types of medical providers, but rather between those medical providers who render regular, on-going treatment and those medical providers who render treatment on an emergency basis.

Not only does §627.736(5)(b), Fla. Stat. (1999) exempt emergency room departments and ambulance services, but it also exempts medical providers, such as physicians and other medical personnel under the supervision of a physician, who provide emergency services and care as defined in §395.002, Fla. Stat. (1999).[4] The legislature made this distinction because it may be

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[4] Section 395.002(10), Fla. Stat. (1999) means:

> [M]edical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician

difficult for medical providers who render services on an emergency basis to obtain insurance information, while a medical provider who provides on-going, regular treatment can insist on verification of the insurance information provided by the patient before initiating any treatment.

Additionally, verifying the need for emergency treatment following a motor vehicle accident is a reasonably simple, straightforward process for a claim representative, while verifying the necessity of on-going treatment may require that a claim representative request that the insured undergo an independent medical examination to assist with the evaluation process. Accordingly, a medical provider who renders treatment in an emergency setting, like hospital emergency departments and ambulance services, would be exempt from the mandates of the statute and would not be disadvantaged or otherwise at risk for nonpayment of his or her bills.

PETITIONERS' argument that a medical provider who must comply with the billing requirement set forth in §627.736(5)(b), Fla. Stat. (1999) is disadvantaged when he or she treats insureds in a hospital setting is nonsensical. Assume, for example, that an insured received treatment by a surgeon while in the hospital and was unable to provide the necessary insurance information to the medical provider because he or she was in a coma or too sick to convey the information. In all likelihood, that physician would be rendering the treatment

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> necessary to relieve or eliminate the emergency medical condition, within the service capable of the facility.

in a hospital. It is inconceivable that this situation would not fall within the exception to the 30/60 day billing requirement. If it were not an emergency, then the surgery was likely a planned event. The physician would certainly have verified insurance coverage before undertaking a surgical procedure or an expensive diagnostic test.

In summary, not only is there a rational legislative reason for imposing the 30/60 day billing requirement, there is a rational purpose for excluding hospital emergency room departments, ambulance services, and other emergency-type treatment from this requirement. Section 627.736(5)(b), Fla. Stat. (1999) does not violate the PETITIONER ROTSTEIN's right to equal protection. Accordingly, the Florida District Court of Appeal for the Fifth District's holding that this statute did not violate PETITIONER ROTSTEIN's right to equal protection should be affirmed.

B. Section 627.736(5)(b), Fla. Stat. (1999) does not violate PETITIONER ROTSTEIN's constitutional right to due process.

The Florida Constitution provides that persons must be afforded due process which encompasses substantive and procedural due process. Article 1, section 9 states, in relevant part, as follows: "No person shall be deprived of life, liberty or property without due process of law."

"The test to be used in determining whether an act is violative of the due process clause is whether the statute bears a reasonable relation to a permissible legislative objective and is not discriminatory, arbitrary or oppressive." Lasky v. State Farm Insurance Company, 296 So. 2d 9, 15 (Fla. 1974). To evaluate

the constitutionality of the statute, the court must "examine the objectives of the Legislature . . . in order to determine whether the provisions of the act bear a reasonable relation to them." Id. The court should not concern itself with "the wisdom of the Legislature in choosing the means to be used, or even with whether the means chosen will in fact accomplish the intended goals." Id. at 15-16. The court should only consider "the constitutionality of the means chosen." Id. at 16.

Section 627.736(5)(b), Fla. Stat. (1999) does not violate the due process clause of the Florida Constitution because the 30/60 day billing requirement comports with rational legislative objectives. The legislative history of the 1998 amendment to §627.736, Fla. Stat. (1999) cites three reasons for imposing the 30/60 day billing requirement.

First, as discussed herein, an insurance company would be in a better position to evaluate whether the treatment provided to an insured was reasonable, necessary, and related to the motor vehicle accident if it receives the statement of charges from the medical provider in a timely manner. Because an insurance company is only required to pay the "reasonable expenses for necessary" treatment that arises out of "the ownership, maintenance, or use of a motor vehicle," and are subject to civil penalties if it does not timely remit payment for medical services rendered to its insureds, it is critical for the insurance company to evaluate the claim as early as possible. The Florida Legislature identified the need for this prompt evaluation of the treatment in the legislative history of the proposed amendment to §627.736, Fla. Stat. (1999).

Second, the 30/60 day billing requirement would benefit consumers by controlling the costs upon which insurance companies base personal injury protection insurance premiums. Insurance companies are in a better position to control their costs if they can more effectively and efficiently evaluate the reasonableness and necessity of claims. The billing requirement gives them the ability to timely evaluate claims. These cost savings would benefit consumers by reducing or controlling the premiums for personal injury protection insurance. Explaining this rationale, the House of Representative's Bill Research & Economic Impact Statement states as follows:

> The 30-day billing requirement and the revision of geographic requirements for an independent medical examination (IME) of a claimant could make the IME a more effective cost-control tool. These cost savings could benefit consumers by reducing the costs upon which insurers based PIP premiums and counteracting upward pressures on PIP premiums.
>
> The bill would reduce a PIP insurer's costs by allowing the insurer to pay certain interest penalties to the state in a lump sum rather than making individual payments of interest amounts of $5 or less. One major insurer has estimated that its cost of issue a check is about $25.

(See Exhibit "G" of Appendix to Respondent's Answer Brief.) Similarly, the Florida Senate cited cost-savings as a rationale for imposing the 30/60 day billing requirement. The Senate Staff Analysis and Economic Impact Statement states as follows:

> The 30 and 60 day billing requirements, the standardization of medical statements and codes, and the revision of geographic requirements for an independent medical examination (IME) of a claimant

> could make the IME a more effective cost-control tool. These cost savings could benefit consumers by reducing the costs upon which insurers based PIP premiums and counteracting upward pressures on PIP premiums. Providers who fail to meet the notice requirement will not be compensated for their services.

(See Exhibit "G" of Appendix to Respondent's Answer Brief.)

Third, the 30-day and 60-day billing requirements would reduce the practice of bulk billing. (See Exhibit "G" of Appendix to Respondent's Answer Brief.) Bulk billing occurs when a medical provider submits multiple bills for services rendered over a long period of time. This practice restricts and interferes with an insurance company's ability to evaluate the necessity of treatment and reasonableness of the charges. An insurance company must have knowledge of the treatment rendered to its insured as early as possible so that it can make a more accurate determination whether the treatment is reasonable, necessary, and related to the motor vehicle accident and to determine whether there is a need to request the claimant to submit to a medical examination pursuant to §627.736(7), Fla. Stat. (1999). If charges are submitted to the insurance company by the medical provider months after the services are rendered (or even years after, as PETITIONERS suggests), the insurance company has no way to realistically and accurately determine the appropriateness of the treatment at the time it was rendered.

PETITIONERS contend that §627.736(5)(b), Fla. Stat. (1999) should be declared invalid because it failed to specifically state that it applied to bulk billing. It appears that PETITIONERS are arguing that a statute should be

declared unconstitutional if the legislature fails to include the underlying rationale for the legislation in the statute itself. PETITIONERS offer no authority to support this argument, nor does it appear that there is any such authority in Florida. While the statute does not specifically discuss bulk billing, the legislative history of §627.736(5)(b), Fla. Stat. (1999) specifically provides that the elimination of the practice of bulk billing was a goal of the 30/60 day billing requirement.

The underlying purpose of the billing requirement (i.e., reducing the amount of premiums for personal injury protection insurance for residents of Florida and allowing insurance companies to fulfill their legislative and contractual duties in providing payment for certain expenses related to motor vehicle accidents) is rationally related to a permissible legislative objective because it promotes the general welfare of the public. This legislative end is achieved without being discriminatory, arbitrary, or oppressive. Accordingly, the billing requirement mandated by §627.736(5)(b), Fla. Stat. (1999) does not violate the due process clause of the federal and Florida constitutions and the Florida District Court of Appeal for the Fifth District did not commit error by reaching this conclusion.

C. Section 627.736(5)(b), Fla. Stat. (1999) does not violate PETITIONER ROTSTEIN's right of access to the courts.

The Florida Constitution provides that persons must be afforded the right of access to the courts. Article 1, section 21 of the Florida Constitution provides as follows: "The courts shall be open to every person for redress of

any injury, and shall be administered without sale, denial or delay."

This Court addressed the conditions under which a statute would violate Article 1, Section 21 and held:

> [W]here a right of access to the courts for redress for a particular injury has been provided by statutory law predating the adoption of the Declaration of Rights of such Constitution of the State of Florida, or where such right has become a part of the common law of the State pursuant to Fla. Stat. s 2.01, F.S.A., the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the State to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown.

Kluger v. White, 281 So. 2d 1, 4 (Fla. 1973). See Nationwide Mutual Fire Insurance Company v. Pinnacle Medical, Inc., 753 So. 2d 55, 57 (Fla. 1999).

In Pinnacle Medical, Inc., this Court considered whether §627.736(5)(d), Fla. Stat. (1999), which required medical providers with assignments from their patients/insurance claimants to attend binding arbitration, violated Article 1, Section 21 of the Florida Constitution. Applying the conditions in Kluger, this Court first addressed whether medical providers who have received assignments had a preexisting right to recover directly from insurers. This Court held "[t]he right of an assignee to sue for breach of contract to enforce assigned rights predates the Florida Constitution." Pinnacle Medical, Inc., 753 So. 2d at 57. As to the second part of the Kluger analysis, this Court considered whether §627.736(5)(d) provided a reasonable alternative to protect

the rights of medical providers with assignments to seek redress for their injuries. Finding the statute did not provide a reasonable alternative because "[t]he limited review and the conclusiveness attached to the arbitration award without the right to a trial de novo diminishes the right to have the ultimate decision in a case made by a court," this Court held that §627.736(5)(d) violated the medical providers' access to courts. Pinnacle Medical, Inc., 753 So. 2d 55 at 57.

Unlike the arbitration provision reviewed by this Court in Pinnacle Medical, Inc., the billing requirement in §627.736(5)(b) does not deny or abolish a medical provider's access to the courts. This statute simply imposes a reasonable time period within which a medical provider such as PETITIONER ROTSTEIN must submit a statement of charges to an insurance company in order to assert a claim for recovery of insurance benefits under the No-Fault Act. Alternatively, this provision is a condition precedent to a medical provider's maintenance of a legal action against an insurance company.

Assuming, arguendo, the 30/60 day billing requirement is considered a restriction upon a medical provider's access to the courts, it would not be an unreasonable restriction which would render the statute unconstitutional. Florida courts have addressed whether the Florida Legislature can enact legislation which imposes restrictions upon a person's access to the courts while not operating to bar the bringing of a claim. In Cates v. Graham, 451 So. 2d 475 (Fla. 1984), this Court considered whether a statute which imposed a four-year statute of limitations on a medical malpractice action was

constitutional as implied. Appellee had operated on appellant to remove broken glass in his foot. Approximately three years and seven months after the operation, appellant discovered that there was still glass in his foot. He filed an action for medical malpractice against appellee more than four and one-half years after the surgery. On appeal, the court considered whether "a five-to six-month period remaining after the discovery of an injury is so short that to enforce the terms of the statute would result in a denial of access to the courts." Id. at 476.

Citing its ruling in Bauld v. J.A. Jones Construction Co., 357 So. 2d 401 (Fla. 1978), this Court held that "a statute of repose is constitutional and does not bar access to the courts when it merely curtails the time within which suit must be filed, as opposed to barring the cause of action entirely." Cates, 451 So. 2d at 476-477. This Court rejected the appellant's argument that "a five-to six-month limitation on bringing an action is tantamount to no right at all." Id. at 477. Although admitting the time period was short, this Court concluded "we cannot say that [appellant] was denied access to the courts by the time constraints" and upheld the constitutionality of the statute as applied. Id.

Similarly, the court in Feil v. Challenge-Cook Brothers, Inc., 473 So. 2d 1338, 1339 (Fla. 1st DCA 1985) held that a statute of repose, which provided that a claim for products liability must be brought 12 years from the date of the delivery of the defective product, did not violate the appellants' right of access to the courts where appellants had four months from the date of their injuries to assert a claim against appellee. The court held that "the four-month period

remaining is sufficient time to furnish appellants access to the courts." Id.

In Blizzard v. W.H. Roof Co., Inc., 556 So. 2d 1237 (Fla. 5th DCA 1990), the court considered whether a Florida statute, which shortened the statute of limitation from four years to one year for negligence actions brought against an insurer that had become insolvent, violated Article I, Section 21 of the Florida Constitution. The court found:

> [U]nder Florida law there is no constitutional violation where a statute merely shortens the time period during which an action may be brought, as opposed to a statute which operates as an absolute bar to bringing an action.

Id. at 1238. The court then held that the statute imposed a reasonable restriction on the appellants' access to the courts. Id.

The statute does not bar PETITIONER ROTSTEIN from bringing a cause of action against RESPONDENT, but simply imposes a time restriction in which the statement of charges must be submitted before asserting a claim against RESPONDENT to recover PETITIONER WARREN's insurance benefits. Under Florida law, the 30 or 60 day time period is not so short as to deny PETITIONER ROTSTEIN a right of access to the courts.

Alternatively, the 30/60 day billing requirement is a condition precedent to PETITIONER ROTSTEIN's maintenance of a lawsuit for recovery of PETITIONER WARREN's insurance benefits. Florida courts have consistently upheld and enforced conditions precedent imposed upon both the insurer and insured by §627.736, Fla. Stat. (1999). In United Automobile Insurance Company v. Viles, 726 So. 2d 320 (Fla. 3rd DCA 1998), the court

considered whether an insurer was required to obtain the report of physician before withdrawing payment of a physician treating its insured pursuant to §627.736(7)(a), Fla. Stat.

[5] The court held that the insurer "was required to first obtain a physician's report before refusing to pay further medical bills." Viles, 726 So. 2d at 321. The court then held that "because [appellant] failed to comply with the statutory condition precedent, its termination of PIP benefits was ineffective." Id.

Similarly, an insured's attendance at a physical or mental examination can be a condition precedent to maintaining a lawsuit against the insurer for recovery of insurance benefits. Florida courts have held that an insurer may be relieved of further liability for benefits if its insured unreasonably refuses to attend a physical or mental examination.[6] See U.S. Security Insurance Company v.

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[5] This statute provides, in relevant part:

> Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been made or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. . . . **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 the treatment was not reasonable, related, or necessary.** (emphasis added.)

[6] Section 627.736(7)(b), Fla. Stat. (1999) provides in pertinent part: "If a person unreasonably refuses to submit to an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits."

Silva, 693 So. 2d 593 (Fla. 3rd DCA 1997) (an insurer is relieved of liability for medical bills incurred after an insured unreasonably refuses to attend a physical examination); Allstate Insurance Company v. Graham, 541 So. 2d 160 (Fla. 2nd DCA 1989) (trial court erred by refusing to grant summary judgment in favor of insurer where the insured unreasonably refused to submit to an independent medical examination); Tindall v. Allstate Insurance Company, 472 So. 2d 1291 (Fla. 2nd DCA 1985) (insurer does not owe insured benefits after the date on which the insured unreasonably refused to submit to a physical examination).

Furthermore, insurance companies must pay claims within 30 days of receipt under §627.736, Fla. Stat. (1999). In the event they fail to comply with this requirement, they may be required to pay attorney's fees, interest, costs, or in some jurisdictions, the entire claim, whether it is reasonable, necessary, and related to the motor vehicle accident or not. This requirement is a condition precedent to the insurance company's maintenance of a defense.

The requirement that a medical provider such as PETITIONER ROTSTEIN submit his bills to the insurer within 30 or 60 days of rendering treatment is no different than the requirement that an insurer obtain a report of physician before withdrawing payment to a physician treating its insured or the requirement that the insured submit to a mental or physical examination in order to assert a claim for benefits against the insurer. Each of these requirements are reasonable conditions precedent to either maintaining an action or defending an action. Such conditions precedent are constitutional and have been consistently

upheld and enforced by Florida courts.

PETITIONERS' contention that §627.736(5)(b), Fla. Stat. (1999) violates the due process clause of the Florida Constitution because PETITIONER ROTSTEIN is a third party beneficiary of the insurance contract and therefore, has five years to bring a legal action for recovery of PETITIONER WARREN's insurance benefits pursuant to §95.11(2)(b), Fla. Stat. (1999) is without merit. There is no conflict between §627.736(5)(b), Fla. Stat. (1999) and §95.11(2)(b), Fla. Stat. (1999). Had PETITIONER ROTSTEIN complied with §627.736(5)(b), Fla. Stat. (1999) and had RESPONDENT denied the bills for some other reason, he would have had five years from the date of the denial of the claim to assert a cause of action against RESPONDENT.

PETITIONERS argue that §627.736(5)(b), Fla. Stat. (1999) is unconstitutional because it requires medical providers to submit their bills within 30 or 60 days while an insured has five years to submit his or her wage claim to the insurance company. This is an entirely inaccurate statement of Florida law. Section 627.736(6)(e), Fla. Stat. (1999) states:

> Notice to an insurer of the existence of a claim shall not be unreasonably withheld by an insured.

A wage loss claim or medical bill submitted five years after it is incurred would certainly be considered "unreasonably withheld" under this statute. PETITIONERS cite no authority, nor can they, that prior to the amendment of §627.736, they had five years to submit their bills to the insurance company for

payment. They have always had – and still have – five years from the date of the alleged breach to file a lawsuit, as long as they themselves have complied with the conditions precedent to the suit.

Section 627.736(6)(e) also requires an employer to provide wage information "forthwith" upon request. If an insured had five years to submit a wage claim to an insurance company, an insurance company would be prejudiced in that it would be virtually impossible to obtain and verify information regarding the insured's employment and wages so long after the insured suffered the lost wages.

To follow PETITIONERS' argument to its logical conclusion would lead to an absurd result. If medical providers can wait five years to submit their bills to an insurance company, it would be impossible for an insurance company to verify whether treatment provided years before was reasonable, necessary, and related to a motor vehicle accident. By the time the insured underwent a medical examination, his or her medical symptoms would likely have resolved or changed so substantially that a medical examination would be useless. PETITIONERS' suggestion that a medical provider has up to five years to submit his or her claim to the insurance company would force an insurance company to pay for all medical treatment rendered to an insured, regardless of whether the treatment was reasonable, necessary, or related to the motor vehicle accident. This result would be contrary to public policy in that it would lead to higher insurance premiums, perpetuate the practice of bulk billing, and be contrary to the No-Fault scheme.

Because the billing requirement in §627.736(5)(b), Fla. Stat. (1999) is not an unreasonable restriction on PETITIONER ROTSTEIN's access to the courts or is a condition precedent to asserting his claim, the statute does not violate PETITIONER ROTSTEIN's right of access to the courts. Therefore, the Florida District Court of Appeal for the Fifth District did not commit error in holding that §627.736(5)(b), Fla. Stat. (1999) does not violate a medical provider's right of access to the courts.

II. THE FLORIDA DISTRICT COURT OF APPEAL FOR THE FIFTH DISTRICT DID NOT COMMIT ERROR BY REVERSING THE TRIAL COURT'S ORDER GRANTING SUMMARY JUDGMENT IN FAVOR OF PETITIONERS AND REMANDING THIS MATTER TO THE TRIAL COURT WITH DIRECTIONS TO GRANT SUMMARY JUDGMENT IN FAVOR OF RESPONDENT.

A. RESPONDENT was entitled to summary judgment as to PETITIONER ROTSTEIN's claim because he failed to timely submit his bills in accordance with §627.736(5)(b), Fla. Stat. (1999).

The Florida District Court of Appeal for the Fifth District was required to apply the de novo standard of review of the trial court's decision granting PETITIONERS' motion for summary judgment and denying RESPONDENT's motion for summary judgment because the trial court's decision was based on legal, not factual, issues. Continental Concrete, Inc. v. Lakes at La Paz III Limited Partnership, 758 So. 2d 1214, 1217 (Fla. 4th DCA 2000).

Section 627.736(5)(b), Fla. Stat. (1999) provides in pertinent part:

> With respect to any treatment or service, other than medical services billed by a hospital for services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the

> provider and may not include, and **the insurer is not required to pay, charges for treatment or services rendered more than 30 days before the postmark date of the statement**, expect for past due amounts previously billed on a timely basis under this paragraph. (emphasis added.)

This Court has held that a court's "responsibility when construing a statute is to give the words their plain and ordinary meaning." Silva v. Southwest Florida Blood Bank, Inc., 601 So.2d 1184, 1186 (Fla. 1992). "'If the language of the statute is clear and unequivocal, then the legislative intent must be derived from the words used without involving incidental rules of construction or engaging in speculation as to what the judges might think that the legislators intended or should have intended.'" Id. (citing Durden v. American Hospital Supply Corp., 375 So.2d 1096, 1098-1099 (Fla. 3d DCA 1979)).

Section 627.736(5)(b), Fla. Stat. (1999), is clear and unambiguous. According to the statute, an insurer is not required to pay charges for medical treatment under a personal injury protection policy if the statement of charges is postmarked more than 30 days after the medical services were rendered.

PETITIONER WARREN treated with PETITIONER ROTSTEIN on May 27, 1999, June 16, 1999, and July 6, 1999 following a motor vehicle accident. PETITIONER ROTSTEIN did not provide RESPONDENT with notice after the initiation of treatment. PETITIONER ROTSTEIN waited until August 9, 1999 to submit a statement of charges to RESPONDENT for the services rendered.

Based upon the clear and unambiguous language of §627.736(5)(b), Fla. Stat. (1999), RESPONDENT was not required to pay for the medical services rendered on those dates. As a matter of law, RESPONDENT was entitled to summary judgment as to PETITIONER ROTSTEIN's claim because PETITIONER ROTSTEIN failed to submit his statement of charges within 30 days of the treatment in violation of §627.736(5)(b), Fla. Stat. (1999). The Florida District Court of Appeal for the Fifth District did not commit error by reversing summary judgment in favor of PETITIONER and remanding this action to the trial court with directions to enter summary judgment in favor of RESPONDENT.

B. RESPONDENT was entitled to summary judgment as to PETITIONER WARREN's claim because he suffered no damages as a matter of law.

Without PETITIONER ROTSTEIN as a party, the litigation should have been dismissed because PETITIONER WARREN, who was the only remaining plaintiff, could not have suffered any damages as a matter of law. Section 627.736(b), Fla. Stat. (1999) specifically provides that an insured is not liable for bills which are not submitted within the required 30 day period. This statute states, in relevant part:

> The injured party is not liable for, and the provider shall not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

Id.

Because the only bills at issue were the three bills from PETITIONER ROTSTEIN, and it is undisputed that PETITIONER ROTSTEIN did not submit those bills within 30 days in accordance with §627.736(b), Fla. Stat. (1999), PETITIONER WARREN cannot suffer any damages as a matter of law. The statute forbids PETITIONER ROTSTEIN from seeking payment from PETITIONER WARREN for the charges he failed to submit to RESPONDENT within 30 days. If PETITIONER WARREN has not suffered any damages, he cannot maintain a cause of action against RESPONDENT as a matter of law. See Sussex Mutual Insurance Company v. Gabor, 568 So.2d 1004, 1005 (Fla. 3rd DCA 1990); Alls v. 7-Eleven Food Stores, Inc., 366 So.2d 484, 486 (Fla. 3rd DCA 1979). Accordingly, the Florida District Court of Appeal for the Fifth District did not commit error by finding that RESPONDENT was entitled to summary judgment as to PETITIONER WARREN's claim.

CONCLUSION

For the foregoing reasons, RESPONDENT respectfully requests that this Court affirm the holding of the Florida District Court of Appeal for the Fifth District, in which the court found that §627.736(5)(b), Fla. Stat. (1999) did not violate the federal or Florida constitutions and that RESPONDENT was entitled to summary judgment as a matter of law.

Respectfully submitted,

_____

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to LARRY M. POLSKY, ESQUIRE, 619 North Grandview Avenue, Daytona Beach, Florida 32118, by U. S. Mail, this ____ day of October, 2002.

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I HEREBY CERTIFY that Times New Roman, 14 point, is used in this Answer Brief.

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