IN THE SUPREME COURT OF FLORIDA

GEICO GENERAL INSURANCE COMPANY,

Appellant,

vs.

CASE NO. 12SC-905

VIRTUAL IMAGING SERVICES, INC.,
a/a/o Maria Tirado,

Appellee.
_______________________________________/

BRIEF OF *AMICUS CURIAE*
FLORIDA JUSTICE REFORM INSTITUTE

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STATEMENT OF IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Florida Justice Reform Institute (the "Institute") is an advocacy organization for civil justice and tort reform that is comprised of concerned citizens, businesses, business leaders, and others aligned in their mission to promote fair and equitable legal practices within Florida's civil justice system. The Institute works to restore faith in the Florida judicial system and to protect Floridians from the social and economic toll that is incurred from rampant litigation. The Institute regularly appears before legislative, executive, and judicial tribunals in support of personal injury protection ("PIP") reforms, including the use of fee schedules to limit provider overbilling.

SUMMARY OF ARGUMENT

The Florida Motor Vehicle No-Fault Law was enacted over forty years ago to ensure that injured drivers receive prompt payment of benefits for medically necessary treatment while minimizing the costs of automobile insurance for all Florida citizens. However, since almost the inception of the Law this goal has consistently been undermined by fraud and abuse. In particular, the Law has allowed a small number of unscrupulous health care providers to grossly inflate charges for medical treatment and services reimbursable by PIP insurance. This overbilling has affected virtually all Florida citizens in the form of dramatically higher PIP premiums.

To combat such overbilling, the Legislature has employed a variety of measures, including the use of fee schedules to cap the rates charged by providers. In 2008, the Legislature finally enacted a comprehensive fee schedule. However, this 2008 fee schedule was preceded by the enactment of fee schedules applicable to a more limited number of diagnostic tests which, at the time, the Legislature deemed to be particularly susceptible to overbilling. Importantly, the legislative history before, during, and after the enactment of these various fee schedules reveals that the Legislature intended to establish a single methodology for reimbursement from PIP insurers: 80% of reasonable medical expenses. The legislative history likewise reveals that due to the uncertainty – and litigation – arising from the term "reasonable", the fee schedules were enacted to eliminate this uncertainty by establishing a cap on reasonable expenses. The fee schedules were not, and were never intended to be, a separate reimbursement methodology.

If the decision of the District Court is allowed to stand, it would effectively remove most, if not all, PIP claims arising under pre-2012 policies from the limitations imposed by the legislatively enacted 2008 fee schedules. Consequently, all Florida insurers will continue to suffer increased losses attributable solely to their inability to enforce the limits set forth in the fee schedules for years to come. These losses, in turn, will be passed on to Florida citizens. This was not the intent of the Florida Legislature.

ARGUMENT

I. Legislative Efforts to Combat Provider Overbilling

In Geico General Ins. Co. v. Virtual Imaging Services, Inc., 79 So.3d 55, 57 (Fla. 3rd DCA 2011) ("Geico I"), the majority argues that Geico:

> was faced with at least two ways of reimbursing reasonable medical expenses: (a) reimbursing Virtual Imaging for 80% of the amount billed, or (b) reimbursing them for 80% of 200% of the amount listed on the Medicare fee schedule.

Although the majority concedes that "[i]t is possible to conclude that '200% of the maximum allowable amount under the fee schedule' is being used to define 'reasonable medical expense'", the majority nevertheless concludes that the statute also could reasonably be interpreted as providing two different, conflicting reimbursement methodologies.[1] Consequently, the majority ruled that the statute is ambiguous and that the "second" methodology was therefore not incorporated by reference into Geico's contract with its insured.[2]

Subsequently, in Geico General Ins. Co. v. Virtual Imaging Services, Inc., 90 So.3d 321 (Fla. 3rd DCA 2012) ("Geico II"), the Third DCA offered two specific examples of the "reasonable" rates charged by providers:

> In this case, the appellee charged $3,600 for the two MRIs in question, and 80% of that amount is $2,880. Under the 2008 amendment, 80% of 200% of the allowable Medicare Part B charge came to $1,989.57. **The "reasonable" charge, established after a**

[1] Id. at 58.
[2] Id.

lawsuit was filed and ruled upon, is over 44% higher than the amount computed using the schedule under the 2008 amendment (without even factoring in the legal and judicial costs of arriving at that result).

In *MGA Ins. Co. v. All X–Ray Diagnostic Services,* Case No. 3D12–414, the x-ray provider billed $2,475, for which 80% or $1,980 was claimed under the PIP policy. The computation under the 2008 statutory amendment came to 80% of $435.22, for an allowable payment of $348.18. **The "reasonable" amount invoiced is over 468% times the amount computed using the fee schedule**.[3]

One of the main flaws in the majority's analysis, as Judge Rothenberg notes in her dissent, is that the majority "incorrectly assumes that the 'amount billed' by providers is 'reasonable.'"[4] In fact, for nearly four decades a small but significant number of providers have charged unreasonably high rates for services reimbursable under personal injury protection ("PIP) polices and thereby thwarted the purpose of Florida's No-Fault law by. Indeed, numerous local and state agencies have consistently emphasized the need to curb the practice of providers charging unreasonably high rates in order for the No-Fault system to survive. For this reason, the Florida Legislature has tried to combat the practice of overbilling since shortly after the No-Fault system was implemented in 1972. Indeed, as early

[3] 90 So.3d at 323 (emphasis supplied). The majority noted immediately thereafter that "[r]unaway medical insurance costs and claims, of course, are borne by our citizens in the form of higher PIP premiums." Id. It is thus not clear whether the Third DCA intended to call into question the reasonableness of the by placing "reasonable" in quotation marks and referencing "runaway" medical insurance costs.

[4] Id. at 66.

as 1976 the Legislature substantially amended the No-Fault law to address the increase in PIP premiums attributed to bill-padding and overutilization of medical benefits.[5] The 1976 amendments were passed in response to a 1975 Miami-Dade County Grand Jury Report addressing "the practice of a small group of lawyers, physicians, osteopaths, chiropractors and hospitals who work together to inflate or outright falsify personal injury claims."[6] Twenty-five years later, the Legislature again passed major reforms to the No-Fault system, this time in response to a Report on Insurance Fraud Related to Personal Injury Protection in August of 2000 by the Fifteenth Statewide Grand Jury.[7] The Grand Jury found:

> Unfortunately, a number of greedy and unscrupulous legal and medical professionals have turned that $10,000 [personal injury protection] coverage into their personal slush fund. Paying kickbacks for patients, abusing diagnostic tests, grossly inflating costs by engaging in sham transactions and filing fraudulent claims of injury, these individuals think nothing of enriching themselves by exploiting the misfortunes of others. The result is loss of coverage and marginal medical treatment for those who are injured, as well as higher insurance rates for all drivers.[8]

The Grand Jury went on to discuss the practice of overcharging for diagnostic services:

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[5] Florida Senate Committee on Banking and Insurance, Florida's Motor Vehicle No-Fault Law: Report Number 2006-102 (Nov. 2005), at 10.

[6] Miami-Dade Co. Grand Jury, Final Report of the Grand Jury (Aug. 11, 1975), at 5, *available at* http://www.miamisao.com/publications/grandjuryreports.htm (last accessed July 17, 2012).

[7] Fifteenth Statewide Grand Jury Report, Report on Insurance Fraud Related to Personal Injury Protection (Aug. 2000) (on file with Clerk, Fla. Sup. Ct.).

[8] Id.

> Some tests are of marginal utility or validity, but all are extremely profitable. One popular test employed by medical professionals engaged in patient solicitation and brokering are nerve conduction studies. One chiropractor who testified before us explained how he paid a technician approximately $100 per patient to conduct these nerve conduction studies in his office. The chiropractor would then bill the insurance company $900 for these same studies. **This enormous markup for diagnostic tests is not customary among legitimate medical professionals.**
>
> * * *
>
> A video fluoroscopy machine can be leased for as little as $1,500 per month and the tests billed at over $650 per five minute examination. The profit potential makes this test extremely attractive to unscrupulous medical practitioners.
>
> **Other diagnostic tests come and go in popularity, but what they all have in common is that they are extremely expensive, highly profitable, and generally employed to drain the $10,000 coverage as quickly as possible**.[9]

The Grand Jury then discussed the susceptibility of MRI testing to charge inflation:

> Because there is no fee schedule set by the government in PIP claims, and because of the strict rules regarding PIP claims, as discussed below, insurance companies must pay almost any amount billed. For example, a lumbar MRI scan would typically be billed on average at $1,700 to a PIP insurer. Medicare, however, would only pay $592 for that same test, a workers compensation carrier would only pay $546, and a typical preferred patient plan would on average pay $653.[10]

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[9] Id.

[10] Id. (Emphasis supplied.)

The Grand Jury made seven recommendations to the Legislature, one of which was to "[c]onsider adopting a fee schedule for reimbursement under the PIP statute similar to the schedule employed in the worker's compensation statute.[11]

As a result of the Grand Jury's Report, the 2001 Legislature passed CS/CS/SB 1092.[12] The Legislature stated that its intent in passing the bill was as follows:

> The Legislature finds that the Florida Motor Vehicle No-Fault Law is intended to deliver medically necessary and appropriate medical care quickly and without regard to fault, and without undue litigation or other associated costs. The Legislature further finds that this intent has been frustrated at significant cost and harm to consumers by, among other things… inflated charges… .
>
> The Legislature further finds insurance fraud related to personal injury protection takes many forms, including, but not limited to… inflated charges for diagnostic tests or procedures arranged through brokers... .
>
> As a result, the Legislature declares it necessary, among other things, to… subject certain diagnostic tests to maximum reimbursement allowances… .
>
> The Legislature further declares the problem of fraud addressed in the Grand Jury report and in this act and matters connected therewith are matters of great public interest and importance to public health, safety, and welfare, and that the specific provisions of this act are the least-restrictive reasonable means by which to solve these problems.[13]

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[11] Id. Previously, only thermogram tests were subject to the worker's compensation fee schedule. Fla. Stat. § 627.736(5)(a) (2000).
[12] 2001 Laws of Fla. ch. 271.
[13] Id.

Although the Legislature did not adopt a comprehensive fee schedule as recommended by the Grand Jury, it did limit reimbursement for spinal ultrasounds, extremity ultrasounds, video fluoroscopy, surface electromyography, and nerve conduction testing to no more than the maximum rates set forth in the worker's compensation fee schedule.[14] It also limited reimbursement for MRI services as follows:

> Effective upon this act becoming a law and before November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 200 percent of the allowable amount under Medicare Part B for year 2001, for the area in which the treatment was rendered. Beginning November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services **shall not exceed** 175 percent of the allowable amount under Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually by an additional amount equal to the medical Consumer Price Index for Florida, except that allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services provided in facilities accredited by the American College of Radiology or the Joint Commission on Accreditation of Healthcare Organizations **shall not exceed** 200 percent of the allowable amount under Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually by an additional amount equal to the medical Consumer Price Index for Florida.[15]

The Legislature adopted these limits knowing that such limits would lower provider reimbursement payments "depend[ing] on the degree to which the amount

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[14] Id.
[15] Id. (Emphasis supplied.)

they charge for these services exceeds the proposed maximum rate."[16] Moreover, although the Legislature did condition reimbursement on the treatment being "medically necessary," the Legislature did not otherwise modify the "reasonableness" requirement of section 627.736(1)(a).[17] Thus, the 2001 Legislature clearly did not believe that limiting reimbursement for certain services to the maximum rates set forth in specified fee schedules would be inconsistent with, contrary to, or otherwise create an alternative methodology to that specified in section 627.736(1)(a).

In 2003, the Legislature passed a number of reforms that both supplemented and clarified those passed in 2001.[18] Included in these reforms was the addition of the following language to section 627.736(5)(a):

> With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, **consideration may be given to evidence of** usual and customary charges and payments accepted by the provider involved in the dispute, and **reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages**, and other information relevant to the reasonableness of the reimbursement for the service, treatment or supply.[19]

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[16] Senate Staff Analysis and Economic Impact Statement, CS/CS/SB 1092 (April 23, 2001).

[17] Supra note 12. "Eighty percent of all reasonable expenses for <u>medically</u> necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and <u>medically</u> necessary ambulance, hospital, and nursing services."

[18] 2003 Laws of Florida ch. 411.

[19] Id. (Emphasis supplied.)

The limitations on reimbursement for certain diagnostic tests remained in place, subject to clarifications regarding which version of the specified fee schedules should be used.[20] The Senate staff analysis of the 2003 legislation reveals how the Legislature intended the PIP reimbursement methodology to function:

> Health care providers may charge "only a reasonable amount for services and supplies rendered" and **in no event may a charge be "in excess of the amount the person (provider) or institution customarily charges for like services or supplies in cases involving no insurance**."[21]

This analysis shows that the Legislature did not consider the limitations on reimbursement for certain diagnostic tests to create an alternative methodology to that imposed by section 627.736(1)(a). Rather, certain diagnostic tests that theretofore had been particularly susceptible to fraud and abuse – e.g., tests for which providers frequently charged rates in excess of the amount "customarily charg[ed]" for such tests – were limited in accordance with specified fee schedules:

> Providers are not subject to a fee schedule for charges for services under the PIP law. However, there are several exceptions, in that certain diagnostic tests are currently subject to the workers' compensation fee schedule under s. 440.13, F.S. These tests include medically necessary cephalic thermograms, peripheral thermograms, spinal ultrasounds, extremity ultrasounds, video fluoroscopy, surface electromyography, and nerve conduction testing.[22]

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[20] Supra note 18.
[21] Senate Staff Analysis and Economic Impact Statement, CS/SB 32-A (May 15, 2003) (emphasis supplied).
[22] Id.

A *limit* on reimbursement is not a *methodology* for determining reimbursement – especially when the reimbursement amount is not a static amount fixed by the rate set forth in the fee schedule. Stated differently, the Legislature intended that providers still be free to bill at whatever reasonable rate they choose, as long as the rate billed does not exceed the maximum statutory rate – i.e., the maximum reasonable rate – as determined by the applicable fee schedule.

In 2005, the Florida Department of Financial Services released a study on the effect of the 2003 changes to the No-Fault law.[23] The Department recommended, among other things, that the Legislature "[a]dopt a mandatory fee schedule for all medical services covered by PIP" in order to "[e]liminate disagreements about the reasonableness of amounts charged and remove inflated billing from the cost drivers of the system."[24] Importantly, the Department did not recommend that the Legislature adopt a fee schedule as an alternative to, or for the purpose of eliminating or replacing, the "reasonableness" requirement of section 627.736(1)(a); rather, the Department recommended that the Legislature adopt the fee schedule for the purpose of conclusively establishing what amount *is* reasonable.

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[23] Florida Department of Financial Services, Study of PIP Insurance Changes, Effect of Changes Pursuant to the Florida Motor Vehicle Insurance Affordability Reform Act of 2003 (2005).
[24] Id.

In November 2005, the Senate Committee on Banking and Insurance released a Report on Florida's Motor Vehicle No-Fault Law citing the Department of Financial Services' Report with respect to the use of fee schedules.[25] After examining both sides of the issue, the Committee recommended that the Legislature:

> Adopt a medical fee schedule for PIP, set at a specified percentage above the Medicare fee schedule. In addition to helping control PIP medical costs, **a fee schedule would also reduce litigation over the reasonableness of medical fees** and thereby reduce PIP loss adjustment expenses and attorney fee awards by insurers.[26]

Like the Department, the Committee did not conclude that a fee schedule should eliminate or replace the reasonableness requirement of section 627.736(1)(a). Instead, the Committee simply concluded that adopting a fee schedule would do what the 2003 amendments did not: lower PIP medical costs and reduce costly litigation by conclusively establishing what amount constitutes a reasonable reimbursement rate.

It was with this history in mind that the 2007 Legislature adopted a comprehensive PIP fee schedule. Put simply, for over three decades the intent of the No-Fault law had been stymied by – among other things – a small class of unscrupulous providers willing to bill for services at grossly inflated rates far in

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[25] Senate Committee on Banking and Insurance, Florida's Motor Vehicle No-Fault Law: Report No. 2006-102 (Nov. 2005) (emphasis supplied).
[26] Id.

excess of what was considered "reasonable." As the Senate staff analysis of the 2007 legislation stated:

> Personal injury protection costs are unnecessarily high in Florida and other no-fault states because, for the most part, there are few cost controls for medical services. The state's no-fault system lacks the cost controls found in health insurance, e.g., fee schedule arrangements with providers, utilization protocols, preferred provider networks, HMO groups.[27]

To combat such unnecessarily high costs, the 2001 Legislature first allowed reimbursement for certain diagnostic tests which were particularly susceptible to abuse to be capped in accordance with specified fee schedules. Then, the 2003 Legislature allowed certain fee schedules to be used as a factor in determining what constitutes a reasonable reimbursement rate for services not then subject to the cap. At no time before, during, or after these amendments was there any suggestion – either by the Legislature or by the courts – that the use of fee schedules for either purpose eliminated or replaced the requirement that providers be reimbursed at a reasonable rate. Indeed, the entirety of the legislative history of section 627.736 is devoid of any suggestion that the use of fee schedules represent a contrary – or alternative – methodology to the reasonable requirement of section 627.736(1)(a). Consequently, the 2007 Legislature's decision allowing insurers to cap reimbursement for all medically necessary services in accordance with 200%

[27] Senate Staff Analysis and Economic Impact Statement, CS/SB 40-C (October 4, 2007).

of the applicable Medicare fee schedule is consistent with nearly four decades of legislative history and furthers the No-Fault law's goals of guaranteeing prompt payment for medically necessary treatment while reducing costs for all Florida citizens.

II. Effect of Limiting Provider Overbilling

The negative effects of high health care costs have been well documented in recent years. In 2011, the Florida Office of the Insurance Consumer Advocate ("OICA") issued a Report on Florida Motor Vehicle No-Fault Insurance.[28] The Report found that "in the last two years, the No-Fault system has been stressed to a point that is inflicting staggering rate increases on consumers."[29] The dramatic rate increases have been necessitated by the corresponding increase in PIP losses suffered by insurers. As the Report notes:

> Based on 2010 financial data reported to the NAIC, insurance companies reported losses exceeding $2.2 billion, up from average losses of $1.6 billion each year from 2006 to 2007. Furthermore, insurance companies paid out $2.7 billion in 2010 for losses and expenses not including overhead expenses. Simply put, for every dollar of premium taken in by insurance companies, $1.15 was paid out in losses and expenses not including overhead expenses.[30]

Importantly, the Report found that this trend "cannot be explained by increases in auto crashes" because "the frequency of auto crashes per 100 licensed

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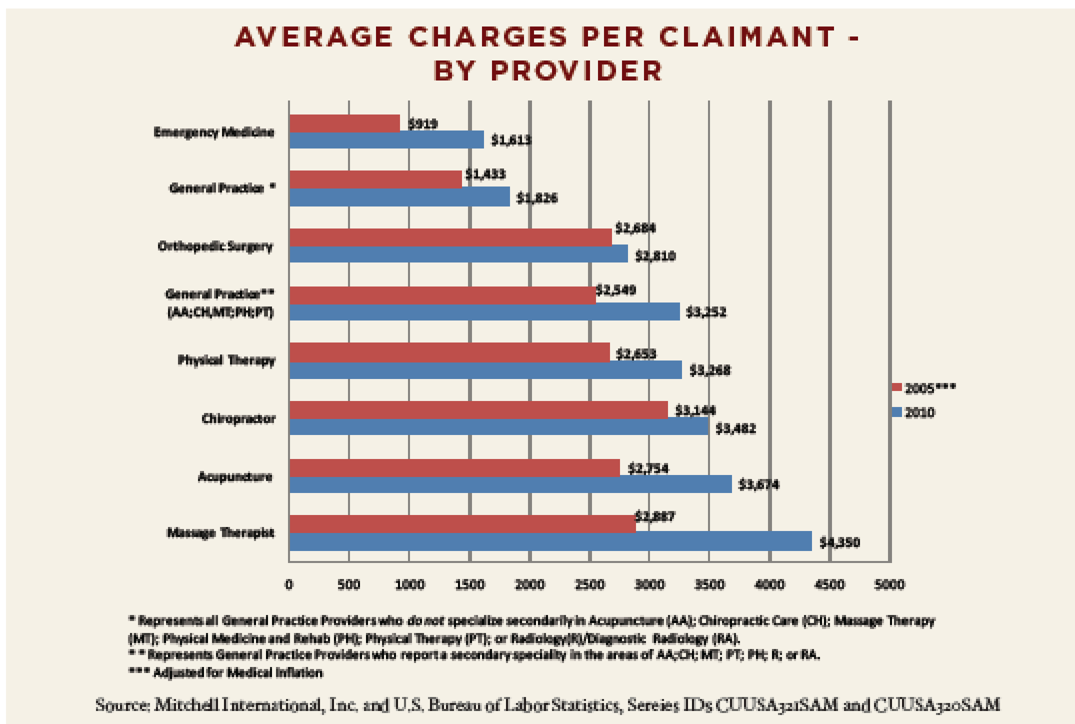
[28] Report on Florida Motor Vehicle No-Fault Insurance, Florida Office of the Insurance Consumer Advocate (Dec.2011).
[29] Id. at 2.
[30] Id.

drivers has been decreasing or constant during the same time period PIP losses were increasing dramatically."[31] Instead, the Report found that one of the cost drivers is the "average cost of procedures per bill."[32] The chart below shows the increase in average charges per claimant by provider for certain services from 2005 to 2010:[33]



These increases are not attributable to medical inflation. Moreover, in addition to the increase in the average amount of charges per procedure, the average number of procedures per claimant has likewise increased since 2007.[34]

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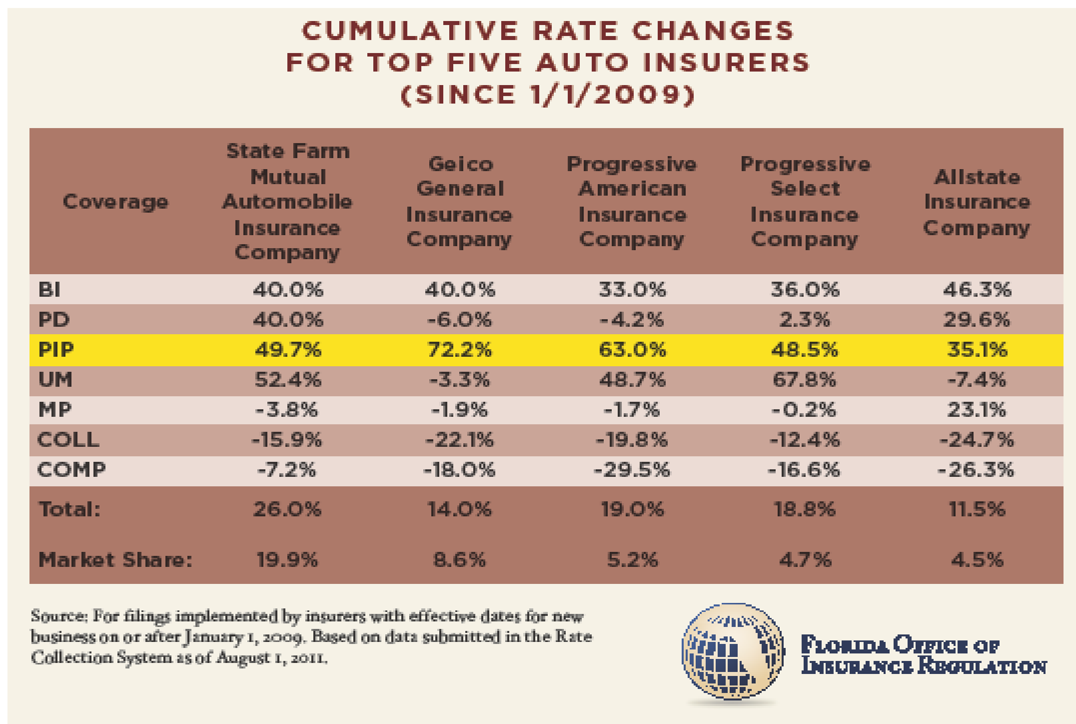
[31] Id. at 7.
[32] Id. at 19.
[33] Id. at 21.
[34] Id. at 19.

The Report notes that this increase in the average number of procedures corresponds with the enactment of the fee schedule in 2008, implying that providers have been able to recoup the compensation lost as a result of the fee schedule by ordering more procedures.[35]

This increase in the volume and value of charges per procedure has led to a dramatic increase in the average PIP premium.[36] In fact, the average PIP rate increases since January 1, 2009, for the top five PIP insurers in the Florida have increased from a low 35.1 percent to a high of 72.2 percent, as evidenced by the chart below.[37]



CUMULATIVE RATE CHANGES FOR TOP FIVE AUTO INSURERS (SINCE 1/1/2009)

Coverage	State Farm Mutual Automobile Insurance Company	Geico General Insurance Company	Progressive American Insurance Company	Progressive Select Insurance Company	Allstate Insurance Company
BI	40.0%	40.0%	33.0%	36.0%	46.3%
PD	40.0%	-6.0%	-4.2%	2.3%	29.6%
PIP	49.7%	72.2%	63.0%	48.5%	35.1%
UM	52.4%	-3.3%	48.7%	67.8%	-7.4%
MP	-3.8%	-1.9%	-1.7%	-0.2%	23.1%
COLL	-15.9%	-22.1%	-19.8%	-12.4%	-24.7%
COMP	-7.2%	-18.0%	-29.5%	-16.6%	-26.3%
Total:	26.0%	14.0%	19.0%	18.8%	11.5%
Market Share:	19.9%	8.6%	5.2%	4.7%	4.5%

Source: For filings implemented by insurers with effective dates for new business on or after January 1, 2009. Based on data submitted in the Rate Collection System as of August 1, 2011.

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[35] Id.
[36] Id. at 6.
[37] Id. at 10.

OICA estimates that, given the fact that "Florida's paid PIP losses per car, per year have increased over 66 percent in just the last 2.5 years," PIP premiums will double every 3 years if this trend continues.[38]

Unfortunately, the Third DCA's decision will only serve to increase the amount of payments made to unscrupulous providers and, in turn, increase the PIP premiums paid by all Florida citizens. As the Report notes:

> At the time, the [2007] legislation appeared to be forthright and the limitations placed on the amount medical providers would receive from PIP benefits were designed to eliminate litigation regarding what is a "reasonable" charge and to reduce fraud and unnecessary medical care.
>
> Unfortunately, the interpretation of this legislation and the fee schedule has been a dominant issue associated with litigation in the No-Fault system. Recently, the Fourth District Court of Appeal, in *Kingsway Amigo Insurance Company v. Ocean Health, Inc*., ruled that the statute allowing an insurer to limit reimbursement according to federal and state medical fee schedules did not allow an insurer whose policy did not mention the limitation to limit its reimbursement.[39]

While the Legislature amended section 627.736 during the 2012 session to require that insurers affirmatively notify the insured of such limitations, the effect of the rulings by the Third and Fourth DCAs is to remove enacted by the 2008 legislature. Consequently, all Florida insurers will continue to suffer increased losses attributable *solely* to their inability to enforce the limits set forth in the fee

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[38] Id. at 6.

[39] Id. at 33.

schedules for years to come. These losses, in turn, will be passed on to Florida citizens in the form of increased PIP premiums – this at a time when unemployment is expected to remain high for years to come and both the state and national economies are still struggling to pull out of a recession. This was not the intent of the Legislature, but it will be the direct result of Geico I and Kingsway Amigo if those decisions are allowed to stand.

CONCLUSION

The intent of the Legislature in enacting the comprehensive fee schedule in 2008 was to definitively cap reimbursement of reasonable medical expenses. The intent was not to establish an alternative reimbursement methodology. The entire legislative history of the No-Fault Law leads inescapably to this conclusion. For these reasons and those set forth herein, the decision of the District Court should be reversed.

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CERTIFICATE OF COMPLIANCE

In compliance with Fla. R. App. P. 9.210(a), the font size used in this *Amici Curiae* Brief is Times New Roman, size 14.

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