**IN THE SUPREME COURT OF FLORIDA**

**CASE NO.: SC12-905**
**L.T. NO.: 3D11-581**

**GEICO GENERAL INSURANCE COMPANY**,

Petitioner,

v.

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

Respondent.

---

# PETITIONER'S INITIAL BRIEF

---

**Frank A. Zacherl**
**Suzanne Youmans Labrit**
**Jerel C. Dawson**
Shutts & Bowen LLP
*Counsel for Petitioner*
4301 Boy Scout Blvd., Ste. 300
Tampa, Florida 33607
Telephone: (813) 227-8113
Facsimile: (813) 227-8213

-and-

1500 Miami Center
201 South Biscayne Blvd.
Miami, Florida 33131
Telephone: (305) 379-9121
Facsimile: (305) 415-9841

## TABLE OF CONTENTS

**Page**

## TABLE OF CITATIONS

**Page(s)**

**Cases**

**Statutes**

**Other Authorities**

## PRELIMINARY STATEMENT

Petitioner (Defendant/Appellant below) is GEICO General Insurance Company ("GEICO"). Respondent (Plaintiff/Appellee below ) is Virtual Imaging Services, Inc. ("Virtual"). Citations to the record on appeal prepared by the trial court clerk appear as R.__. Citations to the Appendix appear as App. __.

## STATEMENT OF THE CASE AND OF THE FACTS

## I. FACTUAL BACKGROUND AND COURSE OF PROCEEDINGS.

Maria Tirado was insured under a Personal Injury Protection ("PIP") policy issued by GEICO in June 2008. App. 2, p.2. Following an automobile accident in September 2008, Ms. Tirado sought treatment from Virtual, which took an assignment of Ms. Tirado's PIP benefits and performed two MRIs. *Id*. Virtual billed GEICO $3600 for such services. *Id*. Pursuant to Fla. Stat. § 627.736(5)(a)2.f.(2008), GEICO paid Virtual $1989.57, which was 80% of 200% of the allowable amount under the participating physicians schedule of Medicare Part B. *Id*. Virtual sued, contending that GEICO could not use the Medicare fee schedules since the subject PIP policy did not reference the "permissive language" of § 627.736(5)(a)2, authorizing insurers to limit provider reimbursement under the Medicare fee schedules. App. 2, pp. 2, 4.

The trial court entered judgment against GEICO, finding that because the fee schedule provisions of Fla. Stat. § 627.736(5)(a)2.f.(2008) are "permissive," they are not automatically incorporated to the PIP policy, notwithstanding the provisions of Fla. Stat. § 627.7407(2008).[1] App. 2, pp. 2-3, 5. On the basis of that conclusion, the trial held that GEICO could not use the fee schedules to determine

[1] "Any PIP policy in effect on or after January 1, 2008 shall be deemed to incorporate the provisions of the Florida Motor Vehicle No-Fault Law." *Id*.

the amount of Virtual's reimbursement, but instead "was required to pay 80% of the reasonable medical expenses (*i.e.*, 80% of $3600) of $2880." *Id*., p. 5.[2]

The trial court certified the following question to the Third District under Fla. Stat. § 34.017:

> MAY AN INSURER LIMIT PROVIDER REIMBURSEMENT TO 80% OF THE SCHEDULE OF MAXIMUM CHARGES DESCRIBED IN F.S. 627.736(5) IF ITS POLICY DOES NOT MAKE A SPECIFIC ELECTION TO DO SO?

App. 2, p. 6. The Third District issued its decision adverse to GEICO (answering the certified question in the negative), and certified to this Court the question of great public importance now on review. *GEICO Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*, 90 So.3d 321 (Fla. 3d DCA 2012) ("*Virtual II*").

## II. THE FEE SCHEDULE OPINIONS/RELATED PROCEDURAL HISTORY.

This appeal is from the most recent decision in a series of cases addressing whether PIP insurers may limit provider reimbursements using the Medicare fee

[2] The crux of this dispute is a purely legal question: can GEICO use the statutory fee schedules to determine the reasonable amount payable to Virtual? To frame the issue for summary judgment, the parties stipulated to certain factual matters underlying the bills at issue. R.17. Virtual contended its charge was reasonable, but acknowledged that "what constitutes a reasonable charge" is a fact question; GEICO agreed "not to challenge [Virtual's] claim that the charge is reasonable." *Id*. ¶3. Virtual argued below that GEICO thereby conceded it had not paid 80% of reasonable expenses. Ans. Br., 13, 20. Nothing could be further from the truth: as the stipulation reflects and the trial court correctly explained, the purpose of the stipulation was to narrow the dispute to GEICO's defense that it properly relied upon the statutory fee schedule to determine -- and pay -- a reasonable charge for Virtual's services. App. 2, p. 1; R.17, ¶¶3, 6.

schedules in Fla. Stat. § 627.736(5)(a)2.f.(2008). The issue was first addressed in *Kingsway Amigo Ins. Co. v. Ocean Health, Inc.*, 63 So.3d 63 (Fla. 4th DCA 2011), *rev. den.*, 86 So.3d 1113 (Fla. 2012) ["*Kingsway*"]. There, the Fourth District determined that the PIP statute "allows an insurer to choose between two different payment calculation methodology options": "80% of incurred medically necessary expenses" [§627.736(1)(a)] **or** "80% of 200% of Medicare Part B fee schedule as provided in subsection 627.736(5)(a)2." *Kingsway*, 63 So.3d at 67. Based on this theory, the court held that an insurer whose policy provides coverage for 80% of reasonable medical expenses may not use the statutorily authorized fee schedules to limit provider reimbursements because the "policy provides greater coverage than the amount required by statute, [so] the terms of the policy will control" and require payment at 80% of the billed amount. *Id*. at 65, 68.

Thereafter, the Third District answered a certified question similar to that presented in *Kingsway*. In *GEICO Indem. Co. v. Virtual Imaging Servs., Inc.*, 79 So.3d 55 (Fla. 3d DCA 2012), *review pending*, Case No. SC12-477 ["*Virtual I*"], the majority adopted *Kingsway*'s "dual methodology" construct, further finding that "ambiguities…necessarily result from incorporating section 627.736(5)(a)2 into the policies" and that "the permissive language of section 627.736(5)(a)2 itself creates ambiguity." *Id*. at 58. Attempting to resolve these "ambiguities" favorably to the insured, the court concluded that "GEICO should have reimbursed Virtual

for the greatest amount possible within the language of the policies." (*i.e.*, 80% of the amount billed). *Id*.

Before the Third District's decision in *Virtual I* became final, the Fourth District issued its decision in *DCI MRI, Inc. v. GEICO Indem. Co.*, 79 So.3d 840 (Fla. 4th DCA 2012), *review pending*, Case No. SC12-701 ["*DCI*"]. In *DCI*, the trial court held that GEICO **was** authorized to use the fee schedules since the PIP "policy incorporated the 2008 No-Fault Law." *Id.* at 841. The Fourth District reversed. Citing *Kingsway*,[3] *DCI* held that insurers whose policies provide coverage for 80% of reasonable expenses (*i.e.*, all PIP policies issued in compliance with Fla. Stat. § 627.736(1)(a)) cannot use the fee schedules to limit provider reimbursements. Focusing on whether insureds know how insurers calculate provider reimbursements, the *DCI* panel opined that although the PIP statute "allow[s] the insurer to opt for another lesser amount" (*i.e.*, the fee schedules), insurers may not use the fee schedules to limit provider reimbursements when "the policy specifically provides for payment of 80% of

[3] The notice of appeal in *DCI* was filed several months before the notice of appeal in *Kingsway*, and GEICO filed its answer brief in *DCI* a month before the answer brief in *Kingsway* was filed. Kingsway and GEICO both filed requests for oral argument in January 2011. Upon learning that *Kingsway* had been set for argument before *DCI*, GEICO attempted to consolidate the cases or otherwise have the court consider the parties' arguments simultaneously, but the court denied all of GEICO's requests and did not set *DCI* for argument until December 2011, long after *Kingsway* became final and was pending review in this Court. *See* App. 3.

reasonable expenses incurred." *DCI*, 79 So.3d at 842. *DCI* also suggests that policies may be ambiguous if the fee schedules are deemed incorporated. *Id*., citing *Virtual I*.[4]

The instant case came up for oral argument on March 5, 2012. By that time, *Virtual I* had become final; GEICO's petition for discretionary review of *Virtual I* was filed in this Court on March 9, 2012, and this Court denied Kingsway's petition for discretionary review on March 16, 2012. On April 25, 2012, the Third District issued its opinion in this case. *GEICO Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*, 90 So.3d 321 (Fla. 3d DCA 2012) ["*Virtual II*"]. As it was bound to do (based on *Virtual I*), the court affirmed, and certified the following question of great public importance:

> WITH RESPECT TO PIP POLICIES ISSUED AFTER JANUARY 1, 2008, MAY THE INSURER COMPUTE PROVIDER REIMBURSEMENTS BASED ON THE FEE SCHEDULES IDENTIFIED IN SECTION 627.736(5)(a), EVEN IF THE POLICY DOES NOT CONTAIN A PROVISION SPECIFICALLY ELECTING THOSE SCHEDULES RATHER THAN "REASONABLE MEDICAL EXPENSES" COVERAGE BASED ON SECTION 627.736(1)(a)?

*Id*. at 322-323, 324.

---

[4] As Judge Rothenberg explained, the *Virtual I* "majority opinion conflicts with *Kingsway*, and is decided on completely different grounds." *Virtual II*, 90 So. 3d at 331 (Rothenberg, J., concurring). In *Kingsway*, the Fourth District found the relevant statutory provisions "unambiguous" and made no finding of ambiguity in the policy; whereas in *Virtual I*, the majority held that the statutory provisions and the policy (identical to the one in *Kingsway*) were ambiguous.

## SUMMARY OF ARGUMENT

There is no question that by enacting the 2008 amendments to the No-Fault Law, including the fee schedule provisions at issue here, the Legislature intended to control provider costs and eliminate endless litigation over "reasonableness" of medical expenses. But this objective is wholly frustrated by the holdings of *Kingsway, Virtual I* and *DCI* (the "Fee Schedule Opinions"). These decisions turn the No-Fault Law on its head by requiring PIP insurers to pay providers the "greatest amount possible", which (a) directly conflicts with insureds' interests in preserving limited PIP benefits and minimizing out-of-pocket expenses; (b) grants unscrupulous providers open season on insurers faced with a Hobson's choice of paying inflated bills or enduring costly litigation; and (c) guarantees continued uncertainty over how medical expenses are to be reimbursed, as well as ongoing litigation on that issue.

The 2008 No-Fault Law unambiguously authorizes insurers to limit provider reimbursements pursuant to the Medicare fee schedules. It contains no requirement that insurers make a policy-based election or otherwise notify insureds that the fee schedules may be used. Had the Legislature intended to enact such a requirement, it could and would have done so. The Legislature knew how to impose such requirements, but did not. This is confirmed by the Legislature's 2012 amendments to the PIP statute, which do impose such a requirement, effective for

policies issued or renewed after July 1, 2012. Because the amendment is not retroactive, there was plainly no election or notice requirement at any time before July 1, 2012.

The Fee Schedule Opinions contravene *Allstate Ins. Co. v. Holy Cross Hosp., Inc.*, 961 So.2d 328 (Fla. 2007) ["*Holy Cross*"], wherein this Court held that PIP insurers may reimburse providers at reduced PPO rates without any such methodology being elected or otherwise mentioned in the policy. The Fee Schedule Opinions also establish that whatever a provider bills is presumptively reasonable, contravening extensive legislative history documenting provider billing abuses, as well as this Court's holding in *Holy Cross* that the amount billed by the provider is not the same as "reasonable expenses."

The Fee Schedule Opinions are premised upon a fundamentally flawed determination that the No-Fault Law creates two distinct and irreconcilable payment methodologies for PIP providers: insurers can pay **either** (a) 80% of "reasonable expenses" (which the Fee Schedule Opinions conflate into 80% of the amount billed) **or** (b) 80% of 200% of the Medicare fee schedule (*i.e.*, twice what providers routinely accept from Medicare), which the Fee Schedule Opinions erroneously deem a "lesser amount" than reasonable expenses. Apart from violating almost every applicable principle of statutory construction, this analysis ignores the Legislative intent which is manifested in the clear statutory language,

and it misapprehends the difference between mandatory coverage requirements of Fla. Stat. § 627.736(1) and provider payment guidelines in § 627.736(5).

Contrary to what the Fee Schedule Opinions hold, the fee schedule provisions in Fla. Stat. § 627.736(5)(a)2 (renumbered in 2012 amendments as § 627.736(5)(a)1) are a legislatively approved method for calculating provider reimbursements so as to satisfy § 627.736(1)'s mandate that insurers provide coverage for 80% of reasonable medical expenses. Any other reading places the two provisions in conflict with one another, thereby rendering the fee schedule provisions meaningless and wholly unusable, a result that could not have been intended and should not be condoned by this Court.

Finally, the most obvious unintended consequence of the Fee Schedule Opinions is to reduce the amount of benefits (medical care) available to PIP insureds and increase their out-of-pocket expenses. As the table below demonstrates, this case presents a perfect example:

| | **Consequence of Denying Fee Schedule** | **Consequence of Applying Fee Schedule** |
|---|---|---|
| Total Available Benefits | $10,000 | $10,000 |
| Billed Amount | $3600 | $3600 |
| Benefits Paid (@80% | $2880 | $1987.57 |
| **Insured's Remaining PIP Benefits** | **$7120** | **$8012.43** |
| **Insured's Out of Pocket Co-pay** | **$720** | **$497.49** |

Here, refusing to allow GEICO to limit Virtual's reimbursement in accord with section (5)(a)2.f has a negative financial impact on the insured of over $1000. Furthermore, the payment to Virtual is over 44% higher than the fee schedule amount, which is twice what Medicare routinely pays for the same service. Under the current decisional framework, this scenario repeats in hundreds, if not thousands, of cases, sometimes resulting in provider payments that exceed the fee schedule amounts by as much as 450% and more, costs which "of course, are borne by our citizens in the form of higher PIP premiums." *Virtual II*, 90 So.3d at 323.

In short, the general purpose of the No-Fault Law is to provide broad coverage to insureds (not to furnish windfalls to their medical providers), and the specific purpose of the fee schedule provisions in subsection 5(a) of the PIP statute is to control provider costs and eliminate costly litigation over pricing of medical services. Both of these purposes are obliterated by the legally flawed Fee Schedule Opinions. This Court should answer the certified question in the affirmative, quash the decision in *Virtual II* and disapprove the Fee Schedule Opinions.

## ARGUMENT

### I. STANDARD OF REVIEW.

The certified question concerns interpretation of the Florida Motor Vehicle No-Fault Law, Florida Statutes §§ 627.730-627.7405(2008), so the standard of review is *de novo*. *Holy Cross*, 961 So.2d at 331.

### II. THE 2008 PIP STATUTE UNAMBIGUOUSLY AUTHORIZES INSURERS TO USE THE FEE SCHEDULES REGARDLESS OF WHETHER THE POLICY 'ELECTS' THE SCHEDULES.

#### A. Background.

The No-Fault Law is a "comprehensive statutory scheme", the purpose of which is to provide medical and other "insurance benefits without regard to fault, and to require motor vehicle insurance securing such benefits." *Holy Cross*, 961 So.2d at 331-332. The "Required Personal Injury Protection" provision (the PIP statute) "is codified at section 627.736 and is an integral part of the no-fault statutory scheme." *Id*. Subsection (1) of the PIP statute outlines the coverage that PIP insurers must provide and requires that insurers pay "eighty percent of all reasonable expenses for medically necessary…services," up to $10,000. Fla. Stat. § 627.736(1)(a).

Fla. Stat. § 627.736(5) governs PIP medical provider charges and insurer reimbursements for those charges, and specifically requires that PIP providers charge insurers "only a reasonable amount" for medical services. *Holy Cross*, 961

So.2d at 332 (quoting subsection 5(a)). Section 627.736(5)(a)2(2008) states in pertinent part:

> 2. The insurer **<u>may</u> limit reimbursement to 80 percent of the following schedule of maximum charges**:
>
> ****
>
> f. For all other medical services [including MRI services]…, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B.

*Id*. (emphasis added).

The fee schedule provisions of subsection (5) have their genesis in a history of PIP provider billing abuses, and were intended to curtail such abuses and eliminate costly litigation over reasonableness of provider charges. *See Virtual II*, 90 So.3d at 328-329 ("the legislative history is replete with evidence demonstrating that providers abused their calculation leverage, leading to widespread fraud and inflation of prices. Prior to the fee schedule's enactment, when presented with an "unreasonable" bill, PIP insurers were often forced to pay the amount billed because their sole alternative was costly litigation.") (Rothenberg, J., concurring); *see also Chiropractic One, Inc. v. State Farm Mut. Automobile*, 92 So.3d 871, 874 (Fla. 5th DCA 2012) (despite multiple amendments to provider payment provisions of PIP statute, legislative goals "have been significantly compromised due to the fraud and abuse that has permeated the PIP insurance market").

Before 2007, the Legislature enacted multiple amendments to subsection (5), with the objective of curbing provider abuses and halting runaway litigation over 'reasonableness' of PIP reimbursements. *E.g.*, *Altamonte Spgs. Imaging, L.C. v. State Farm Mut. Auto. Ins. Co.*, 12 So.3d 850, 857 (Fla. 3d DCA 2009) (discussing history of 2001 amendments concerning MRI provider reimbursements, and observing that the "legislature inadvertently spawned competing interpretations and the potential for thousands of microlawsuits in which attorneys would recover far more than the adjustments payable to the MRI providers"); *Millennium Diagnostic Imaging Ctr., Inc. v. Sec. Nat. Ins. Co*., 882 So.2d 1027, 1029 (Fla. 3d DCA 2004) (noting a "cavalcade of litigation" regarding amounts payable to MRI providers under subsection (5)). In 2007, the Legislature revived and amended the PIP statute (which, by virtue of the 2003 amendments, sunsetted in October 2007), and established the Medicare fee schedules as an objective standard upon which insurers and providers could rely to determine reasonableness of charges for medical services. *See* Comm. On Banking & Ins., Florida's Vehicle No-Fault Law, Report No. 2006-102 at 62, 96-97 (recommending the Legislature adopt a fee schedule for PIP tied to Medicare schedules, in order to "control PIP medical costs…[and] reduce litigation over the reasonableness of medical fees").

It is no secret that the Legislature's goal of curbing the litigation explosion over inflated provider charges has yet to be achieved, and the instant case is a

prime example of how the Legislature's intent is being thwarted. Avaricious providers, cloaking their self-interest in higher payments under the garb of broader coverage for insureds, have made a mockery of the Legislature's clear directives, this time by persuading the courts of this State that it is unreasonable for PIP insurers to pay providers twice what Medicare pays for routine clinical services. Notwithstanding the providers' self-serving arguments, the current and demonstrably erroneous judicial interpretations of the provider reimbursement provisions of the No-Fault Law work a profound disservice to the interests of PIP insureds, and contribute to ever-rising PIP costs in Florida.

### B. The PIP Statute Does Not Require an 'Election' to Use the Fee Schedules.

The fundamental goal of statutory interpretation is to "effectuate the intent of the Legislature." *Borden v. East-European Ins. Co.*, 921 So.2d 587, 595 (Fla. 2006). To determine that intent, courts look primarily to the "actual language used in the statute." *Id*.; *see also Hill v. Davis*, 70 So.3d 572, 575 (Fla. 2011) (recognizing that statutory text is the "most reliable and authoritative expression of the Legislature's intent"). "Where the wording of the [No-Fault] Law is clear and amenable to a logical and reasonable interpretation, a court is without power to diverge from the intent of the Legislature as expressed in the plain language." *Holy Cross*, 961 So.2d at 334 (citations omitted).

That the Legislature intended for insurers to use the fee schedules -- without expressly 'electing' to do so in their policies -- is demonstrated by Fla. Stat. § 627.7407(2)(2008), which was enacted simultaneously with Fla. Stat. § 627.736 (5)(a)2, and which specifically states that any PIP policy in effect on or after January 1, 2008 "shall be deemed to incorporate the provisions of the Florida Motor Vehicle No-Fault Law, as revived and amended by this act." Accordingly, the schedules were automatically incorporated as a matter of law to every PIP policy in effect on or after January 1, 2008. *Grant v. State Farm Fire & Cas. Co*., 638 So.2d 936, 938 (Fla. 1994); *see also U.S. Sec. Ins. Co. v. Magnetic Imaging Sys., I, Ltd*., 678 So.2d 872, 873 (Fla. 3d DCA 1996) ("the policy is to be construed in a way which brings it into compliance" with the PIP statute).

This alone negates the conclusion that PIP policies must 'elect' the fee schedules before insurers may rely on the fee schedules in calculating provider reimbursements. But even if the incorporation provisions of Fla. Stat. § 627.7407(2) are ignored, it is clear from the plain language of § 627.736(5)(a)2 that the Legislature intended to authorize insurers to use the fee schedules to limit provider reimbursements, regardless of whether a given policy 'elects' or references the schedules.

The word "may," when used in a statute, is a "discretionary word." *Burdick v. State*, 594 So.2d 267, 271 (Fla. 1992). It "confers a discretionary power" to do

something. *Apex Plumbing Supply, Inc. v. U.S. Supply Co.*, 142 F.3d 188, 192 (4th Cir. 1998), *cert. den.*, 525 U.S. 876 (1998).; *see also Nationwide Mut. Ins. Co. v. Jewell*, 862 So.2d 79, 85 (Fla. 2d DCA 2003) ["*Jewell*"], *approved*, *Holy Cross*, 961 So.2d 328 ("may" is a "permissive" term about which "[t]here is nothing uncertain or ambiguous"). Here, by permissively authorizing insurers to limit reimbursements in accord with the fee schedules, the Legislature clearly expressed its intent to give PIP insurers discretion to use the fee schedules; it expressed no intent to prohibit use of the fee schedules. *See Jewell*, 862 So.2d at 85 ("[a]bsent some clear warrant for doing so in the statutory context, permissive provisions should not be read to impose an implied prohibition").

This discretion is not unfettered -- the Legislature placed specific limits on it. For example, while the applicable fee schedule is the one in effect at the time services were rendered, reimbursements subject to Medicare Part B cannot be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007. Fla. Stat. § 627.736(5)(a)3(2008) (renumbered in 2012 amendments as § 627.736(5)(a)2).

The Legislature's limitations on insurers' discretionary use of the fee schedules do not include any requirement that a PIP policy must contain an 'election' to use the schedules. When a statute "enumerates the things on which it is to operate, or forbids certain things, it is ordinarily to be construed as excluding

from its operation all those not **expressly** mentioned." *Locke v. Hawkes*, 595 So.2d 32, 36 (Fla. 1992) (emphasis in original). Quite simply, had the Legislature intended to restrict insurers' rights under § 627.736(5)(a)2 to policies 'electing' the schedules, the Legislature would have done so expressly by placing such restrictive language in the statute. *See In re McCollam*, 612 So.2d 572, 574 (Fla. 1993) ("had the legislature intended to limit the exemption to particular annuity contracts, it would have included such restrictive language" in the statute); *see also Orion Ins. Co. v. Magnetic Imaging Sys. I*, 696 So.2d 475, 477 (Fla. 3d DCA 1997) ("refus[ing] to hold that the Legislature intended to require specific language in insurance policies which would have no effect or meaning").

The Legislature's intent not to restrict use of the fee schedules to policies 'electing' them is confirmed by another provision of the PIP statute in which the Legislature **did** limit an insurer's right to do something by requiring that it be stated in a policy. Section 627.736(7) provides that PIP insurers are "**authorized to include reasonable provisions in personal injury protection insurance policies**" for mental and physical examination of persons claiming PIP benefits (emphasis added). Thus, an insurer wishing to conduct mental and physical examinations of claimants must include a policy provision to that effect. Tellingly, the Legislature did **not** phrase § 627.736(5)(a)2(2008) in this manner, though it certainly could have (*e.g.*, "insurers **may include provisions in personal injury**

**protection insurance policies** limiting reimbursement to 80 percent of the following schedule of maximum charges"). Likewise, the enabling provisions for the 2008 reenactment of the No-Fault Law do require insurers to provide various specific notices to insureds by November 15, 2007, but are utterly bereft of any reference to a notice or 'election' regarding the fee schedules. *See* Fla. Stat. § 627.7407(5)(2008) .

It is a "well-settled rule of statutory construction" that when the Legislature "includes particular language in one section of a statute but not in another section of the same statute, the omitted language is presumed to have been excluded intentionally." *Bd. of Trustees of Fla. State Univ. v. Esposito,* 991 So.2d 924, 926 (Fla. 1st DCA 2008); *see also Industrial Fire & Cas. Ins. Co. v. Kwechin,* 447 So.2d 1337, 1339 (Fla. 1984). It must therefore be presumed that the Legislature intentionally omitted from § 627.736(5)(a)2(2008) any requirement that the fee schedules be 'elected' or otherwise referenced in policy provisions. *E.g*., *Stone v. Jackson Nat'l Life Ins. Co.,* 934 So.2d 532, 534 (Fla. 3d DCA 2006) ("the statute does not mandate that its requirements be included in life insurance policies, and we cannot read those requirements into the policy").

Furthermore, the Insurance Code contains numerous instances of the Legislature directing insurers to modify their policies if they wish to avail themselves of a permissive statutory authorization. *E.g.*, Fla. Stat. § 627.702(8)

(property insurers "may, by an appropriate rider or endorsement or otherwise, provide insurance indemnifying the insured for the difference between…"); § 627.4136(3) (insurers have the "right to insert in liability insurance policies contractual provisions" preventing liability insurers from being joined as party defendants with insureds).

In sum, the Legislature did not impose any notice requirements or policy-based restrictions on insurers' use of the fee schedules, and courts cannot do so in the Legislature's stead. *Dadeland Depot v. St. Paul Fire & Marine Ins. Co.,* 945 So.2d 1216, 1222 (Fla. 2006) (court's task is to "provide construction of…[the statute] as enacted by the Legislature and its application as written, not as we might think it should have been written"). This Court need look no further than the statute's plain text to discern the clearly expressed legislative intent that insurers may use the fee schedules regardless of whether the policy contains an 'election' to do so. The certified question should be answered affirmatively.

## III. THE 2012 AMENDMENTS DEMONSTRATE THAT INSURERS WERE NOT REQUIRED TO ELECT OR REFERENCE THE FEE SCHEDULES IN POLICIES PRIOR TO JULY 1, 2012.

The permissibility under the 2008 PIP statute of using the fee schedules without 'electing' them in a policy is additionally confirmed by the Legislature's 2012 amendments to the No-Fault Law. *See generally* Ch. 2012-197, Laws of Fla.

(the "2012 Amendments"). Fla. Stat. § 627.736(5)(a) was amended by adding the following new paragraph:

> 5. **Effective July 1, 2012,** an insurer may limit payment as authorized in this paragraph only if the insurance policy includes **a notice at the time of issuance or renewal** that the insurer may limit payment to the schedule of charges specified in this paragraph….

Fla. Stat. § 627.736(5)(a)5(2012) (emphasis added).

It is indisputable that this amendment is not retroactive. Under Florida law, it is presumed that statutory amendments are "intended to operate prospectively" absent some "clear legislative expression to the contrary." *State v. Lavazzoli*, 434 So.2d 321, 323 (Fla. 1983). As to the 2012 amendment quoted above, there is no expression of retroactive intent. On the contrary, by providing a specific effective date of July 1, 2012, the Legislature made clear that the amendment only applies **after** July 1, 2012. *See GEICO Indem. Co. v. Physicians Group, LLC*, 47 So.3d 354, 357 (Fla. 2d DCA 2010) (holding that 2008 No-Fault Law did not apply retroactively because § 627.7407(2) provided that it applied to policies "in effect on or after January 1, 2008"). The Legislature's "inclusion of an effective date … effectively rebuts any argument that retroactive application of the law was intended." *State v. Zuckerman-Vernon Corp.*, 354 So.2d 353, 358 (Fla. 1977).

By changing the law -- effective July 1, 2012 -- to allow insurers to use the fee schedules only if the policy includes notice, the Legislature confirmed what is

already clear: that no such notice was required **before** July 1, 2012. *See Menendez v. Progressive Exp. Ins. Co.*, 35 So.3d 873, 879 (Fla. 2010) (holding that 2001 amendments to PIP statute imposing pre-suit notice requirements did not apply retroactively because such provisions "constitute[d] a substantive change to the statute in effect at the time the insureds' insurance policy was issued."). Had notice or an 'election' been required before then, there would have been no need for the amendment. It is "presumed that in adopting an amendment, the legislature intends to **change** the meaning of a statute unless a contrary intention is clearly expressed." *Equity Corp. Holdings, Inc. v. Dep't of Banking and Finance*, 772 So.2d 588, 590 (Fla. 1st DCA 2000) (emphasis in original); *Carlile v. Game & Fresh Water Fish Comm'n*, 354 So.2d 362, 364 (Fla. 1978) ("when a statute is amended, it is presumed that the Legislature intended it to have a meaning different from that accorded to it before the amendment.").

Indeed, another section of the 2012 Amendments makes clear that insurers are authorized to use the fee schedules without any 'election' or notice even **after** July 1, 2012, until current policies expired and new ones were issued (or the old ones renewed). As part of the 2012 Amendments, the Legislature added new Fla. Stat. § 627.7311 to the No-Fault Law, and it provides that:

> The provisions and procedures authorized in ss. 627.730-627.7405 shall be implemented by insurers offering policies pursuant to the Florida Motor Vehicle No-Fault Law. **The Legislature intends that these provisions**

> **and procedures have full force and effect regardless of their express inclusion in an insurance policy form, and a specific provision or procedure authorized in ss. 627.730-627.7405 shall control over general provisions in an insurance policy form.** An insurer is not required to amend its policy form or to expressly notify providers, claimants, or insureds in order to implement and apply such provisions or procedures.

Fla. Stat. § 627.7311 (2012) (emphasis added). When this section is read together with the new § 627.736(5)(a)5 -- which requires "notice at the time of issuance or renewal" -- it is clear that the Legislature intended to authorize insurers to continue using the fee schedules (regardless of whether the policy contains an 'election' or other notice regarding their use) until insurers comply with the new § 627.736(5)(a)5 by including notice in policies issued or renewed after July 1, 2012.

Virtual likely will argue that by amending subsection (5)(a)5, the Legislature intended to clarify, rather than change, the meaning of the pre-amendment statute. But given the Legislature's specifically chosen effective date for the amendment, this interpretation is strained at best. Moreover, logic dictates that legislative clarification is necessary only when a statute is ambiguous, as an unambiguous law needs no clarification. *See Dadeland Depot*, 945 So.2d at 1230 (this Court is "reluctant to look at subsequent amendments to determine legislative intent when the language of a statute is clear and unambiguous"), citing *Savona v. Prudential Ins. Co. of America*, 648 So.2d 705, 707 (Fla. 1995) (rejecting insured's contention

that unambiguous statute "should yield to the legislative intent as evidenced by subsequent amendments to the statute").

As demonstrated above, the 2008 PIP statute unambiguously authorizes insurers to use the fee schedules with no requirement that a policy 'elect' to do so. When the Legislature saw fit in 2012 to impose a notice requirement for policies issued or renewed after July 1, 2012, it enacted a new statutory provision to that effect. Because the pre-amendment statute was unambiguous, the amendment **changed** the law; it did not clarify the previous law. *Carlile*, 354 So.2d at 364; *cf. Millennium Diagnostic*, 882 So.2d at 1029 (where pre-amendment statutory language only generally referenced Medicare Part B, amendment that identified specific Medicare schedule to be consulted in determining MRI provider reimbursement was a "clarification of the legislature's intent on what an 'allowable amount' would be").

*Country Vintner of N. Carolina, LLC v. E & J Gallo Winery, Inc.*, 461 Fed.Appx. 302, 2012 WL 29166 (4th Cir., Jan. 6, 2012), is on point with respect to the significance of the 2012 Amendments to this case. In *Country Vintner*, the court applied the North Carolina Wine Distribution Agreements Act (the "Wine Act") as it existed in 2008-2009. *Id*. at **1. The appellant, a wine wholesaler, sought certain statutory protection under the Wine Act, but the court found that the plain language of the statute did not provide the protection, which involved rights

to continued distribution of a brand. *Id.* at **5. The court further noted that in 2010, the Wine Act was amended "specifically to grant (prospectively) the very type of protection that [appellant] seeks in this case." *Id*. Reiterating its holding that the pre-amendment Wine Act afforded the wholesaler no protection, the court reasoned that the amendment "demonstrates that the North Carolina General Assembly knew how to protect a wholesaler's right to the continued distribution of a brand, **yet previously chose not to do so**." *Id.* at **6 (emphasis added).

Summarizing, the 2012 Amendments demonstrate that the Legislature knew how to require fee schedules to be referenced or 'elected' in policy provisions, yet chose not to do so until 2012. As this case concerns the operation of the 2008 version of the statute, the certified question must be answered in the affirmative.

## IV. THE FEE SCHEDULE OPINIONS ARE WRONGLY DECIDED.

### A. The Fee Schedule Opinions Contravene *Holy Cross*.

In *Holy Cross,* this Court established that insurers may reimburse PIP providers at reduced rates if authorized by the PIP statute -- regardless of whether such statutory authorization is mentioned in or is part of the PIP policy -- and that payment at such reduced rates does not violate the mandatory coverage requirement of the PIP statute. In *Holy Cross*, the insureds were treated at a hospital, which billed the insurer. 961 So.2d at 330. The insurer "paid eighty percent of a reduced rate" based on separate contracts the hospital and the insurer

had with a preferred provider ("PPO") network (Beech Street). *Id*. The hospital challenged the payments, asserting that under the mandatory coverage provisions of subsection (1)(a), the insurer "could not take advantage of any reduced rates and was required to pay eighty percent of all reasonable medical expenses" because the insureds did not have PPO policies with the insurer and the insurer did not have a direct PPO contract with the hospital. *Id*. at 331. Rejecting this argument, this Court held that:

> [p]ayment at a reduced rate does not violate subsection (1)(a) so long as the insurer pays eighty percent of all **reasonable** expenses. What a provider customarily charges or has previously accepted are important factors for determining whether a fee is reasonable. This is especially true where the provider has agreed to accept a certain fee as a reasonable payment [for particular services].

*Id*. at 335 (emphasis in original) (citations omitted).

This Court reached this conclusion despite the fact that the insurer had neither a PPO PIP policy with the insured nor a direct contract with the hospital. *Id*. at 331. Meaning, **the insured had a standard PIP policy with no mention of PPO arrangements or provider payments at reduced rates**. Despite the lack of any notice or 'election' in the subject PIP policy, this Court found that the PIP insurer could reimburse providers at reduced PPO rates. *Id*. at 330, 335-56.

*Holy Cross* applies directly here. The PPO agreement between the hospital and Beech Street -- *i.e*., an indirect arrangement whereby the provider accepted

reduced rates for particular services -- parallels the Medicare framework whereby providers accept reduced rates (the fee schedule amounts) for particular services. Applying *Holy Cross* to this case dictates the conclusion that an insurer need not 'elect' the fee schedules in a policy as a condition to their use, because (a) the statute authorizes use of the fee schedules and (b) providers routinely accept the fee schedule rates from Medicare. Thus, reimbursing providers at 80% of **twice** those rates cannot violate the insurer's obligation under subsection (1)(a) to provide coverage for **reasonable** expenses. *See also Jewell*, 862 So.2d at 86 ("Insofar as the provisions of the no-fault law and of the PIP policies are concerned, there is simply no basis for complaining that a payment rate a provider has agreed to accept is inadequate and therefore not reasonable.").

*Virtual I*'s conflation of reasonable expenses with the amount billed also contradicts *Holy Cross*. *See Virtual* I, 79 So.3d at 57. As Virtual did here, the provider in *Holy Cross* argued that because the subject policy did not contain notice that providers would be paid at reduced rates, the insurer was required to "pay eighty percent of all **reasonable medical expenses, i.e., eighty percent of the full bill as charged**, as set forth in section 627.736(1)(a)." 961 So.2d at 331 (emphasis added). This Court disagreed, holding that payment at a reduced rate does not violate the coverage requirement of "subsection (1)(a) so long as the insurer pays eighty percent of all **reasonable expenses**." *Id*. at 335 (emphasis in

original). Thus, *Holy Cross* established that "reasonable expenses" does not mean "billed amount."[5]

### B. There is No Dual Methodology for Payment of PIP Benefits.

Subsection (1) of 627.736 specifies the PIP coverage and benefits that insurers must provide; § 627.736(1)(a) requires PIP insurers to provide coverage for "eighty percent of all **reasonable** expenses" for medically necessary services. *Id*. (emphasis added). Subsection (5) of 627.736 specifies guidelines for PIP medical providers and insurers in determining the reasonableness of charges for medical services and for the payment of same. Fla. Stat. § 627.736(5)(a)1 states that in determining the reasonableness of medical provider charges, "consideration may be given to…various federal and state medical fee schedules," and subparagraph (5)(a)2 specifically authorizes insurers to limit reimbursements to "80 percent of the following schedule of maximum charges" -- for MRI services like those at issue here, the specified schedule is "200 percent of the allowable amount under the participating physicians schedule of Medicare Part B." Fla. Stat. § 627.736(5)(a)2.f.

---

[5] *Virtual I*'s presumption that the billed amount is *per se* reasonable is also contrary to legislative history, which documents "widespread fraud and inflation of prices" by providers before the enactment of the fee schedules. *Virtual II*, 90 So.3d at 328 (Rothenberg, J., concurring). The Legislature enacted the fee schedule provisions in 2008 to "curtail the calculation leverage historically wielded by providers by statutorily affording insurers the unilateral option of limiting reimbursement under a safe harbor schedule of maximum charges." *Id.* at 330.

A primary flaw in *Kingsway* is the core holding that these complementary statutory provisions create two distinct (and irreconcilable) payment "methodologies." *Kingsway* requires insurers "to choose between two different payment calculation methodology options": "80% of incurred medically necessary expenses" (§627.736(1)(a)) **or** "80% of 200% of Medicare Part B fee schedule as provided in subsection 627.736(5)(a)2." *Kingsway*, 63 So.3d at 67 (emphasis added). Relying on *Kingsway*, the *Virtual I* majority concluded that because "section 627.736(5)(a)2 provides that insurers "may" consult the Medicare fee schedule…[it] afford[s] insurers a choice between two different payment calculation methodologies", *i.e.*, "(a) reimbursing Virtual for 80% of the amount billed, or (b) reimbursing them for 80% of 200% of the amount listed on the Medicare fee schedule." *Virtual I*, 79 So.3d at 57-58.

Florida law requires courts to "construe related statutory provisions in harmony with one another." *School Bd. of Palm Beach County v. Survivors' Charter Schools, Inc.*, 3 So.3d 1220, 1234 (Fla. 2009) (citation omitted). This is particularly important when the statutory provisions at issue are part of a "unified and comprehensive statutory scheme," *Hill*, 70 So.3d at 577, which the PIP statute certainly is. *Holy Cross*, 961 So.2d at 331-332 ("[t]he No-Fault Law is a comprehensive statutory scheme"). When construing such a scheme, courts are "admonished not to read statutory language in isolation." *O'Hara v. State*, 964

So.2d 839, 843 (Fla. 2d DCA 2007) (citing *Thompson v. State*, 695 So.2d 691, 692 (Fla. 1997)). Rather, particular language "must be taken in context, so that its meaning may be illuminated in the light of the statutory scheme of which it is a part." *Id*.

When §§ 627.736(1)(a) and 627.736(5)(a)2 are read together, as they must be, they clearly do not provide two separate payment methodologies. The No-Fault Law imposes a single, mandatory coverage requirement: insurers must reimburse 80% of reasonable medical expenses. §627.736(1)(a). The fee schedule "methodology" in subsection (5)(a)2 necessarily embodies the Legislature's determination that reimbursement of medical expenses at rates tied to (and higher than) Medicare reimbursement rates is "reasonable" for purposes of satisfying the coverage mandate.[6]

Contrary to what *Virtual I* concluded, the coverage requirement of § 627.736(1)(a) is not optional, it is mandatory. PIP insurers "**shall** provide personal

[6] At bottom, the "two methodology" holdings confuse coverage requirements with provider payment guidelines. *See Holy Cross*, 961 So.2d at 332 (subsection 1(a) "outlines the coverage that PIP insurers must provide…[which is] eighty percent" of reasonable medical expenses; subsection (5) sets forth payment "guidelines for both PIP insurers and medical providers, including how and when charges must be submitted and benefits paid"); *see also Warren v. State Farm Mut. Auto. Ins. Co*., 899 So.2d 1090, 1094, 1096 (Fla. 2005) (Legislature is entitled to enact specific procedures to implement PIP statutory scheme, including the provisions of subsection (5)(a), which governs how providers "receive payment" for medical services).

injury protection…[for] eighty percent of all reasonable expenses. *Id*. (emphasis added). The word "shall" is, of course, "mandatory in nature." *Sanders v. City of Orlando*, 997 So.2d 1089, 1095 (Fla. 2008). Because there are "no exceptions listed anywhere in the statute," the requirement that insurers provide coverage for 80 percent of reasonable expenses is "unequivocally mandatory across the board." *Virtual II*, 90 So.3d at 332 (Rothenberg, J., concurring).

If the "permissive" fee schedule "methodology" of § 627.736(5)(a)2 provides a separate and different alternative to the mandatory coverage requirement of § 627.736(1)(a), then any insurer using the fee schedules -- regardless of whether the subject policy contains an 'election' -- would in fact be violating § 627.736(1)(a), precisely because the latter provision is mandatory. In other words, § 627.736(5)(a)2 would be in conflict with § 627.736(1)(a). But statutory provisions are to be "read as consistent with one another rather than in conflict, if there is any reasonable basis for consistency." *Allstate Ins. Co. v. Rush*, 777 So.2d 1027, 1032 (Fla. 4th DCA 2000) (citing *State v. Putnam County Dev. Auth.*, 249 So.2d 6 (Fla. 1971)), *rev. dism'd*, 790 So.2d 1101 (Fla. 2001). Whenever possible, it is the "duty of the courts to adopt that construction of a statutory provision which harmonizes and reconciles it with other provisions of the same act." *Woodgate Dev. Corp. v. Hamilton Inv. Trust*, 351 So.2d 14, 16 (Fla. 1977).

Here, it is a simple matter for the Court to carry out its duty of harmonizing § 627.736(1)(a) and § 627.736(5)(a)2. Reading the two provisions together, it is clear that the Legislature "intended that all reimbursements under the PIP fee schedule must satisfy the mandatory reimbursement requirement." *Virtual II*, 90 So.2d at 332 (Rothenberg, J., concurring). In other words, the only reasonable interpretation of § 627.736(5)(a)2 in harmony with subsection (1)(a) is that it establishes a "safe harbor" for reasonable reimbursements to PIP providers. This conclusion directly parallels this Court's analysis in *Holy Cross* where it harmonized the mandatory coverage requirements of subsection (1)(a) with the 'permissive' provisions of § 627.736(10) (now § 627.736(9)) authorizing insurers to enter into PPO arrangements and pay providers reduced rates thereunder.

Even the *Virtual I* majority found it "possible to conclude that 200% of the maximum allowable amount under the fee schedule is being used to define reasonable medical expense." *Virtual I*, 79 So.3d at 58 (internal quotation marks omitted). But that conclusion is not merely "possible"; it is inescapable. What the *Virtual I* majority overlooked is the mandatory nature of § 627.736(1)(a). Because the coverage requirement of § 627.736(1)(a) is mandatory, it is **not** logically possible to conclude, as the *Kingsway* and *Virtual I* courts did, that there are "two alternatives" for reimbursement, *i.e.*, that paying providers eighty percent of twice the maximum amount allowed by Medicare is somehow not "reasonable." *See*

*also DCI*, 79 So.3d at 842 (holding that reimbursement under the statutory fee schedule provisions is a "lesser amount" than "80% of reasonable expenses" specified in coverage provisions of PIP policy). Quite simply, it makes no sense that the Legislature would decide that insurers can pay medical providers less than a "reasonable" amount[7] simply by including boilerplate notices in insurance policies -- which medical providers do not even see before treating insureds.

Under the logic of *Virtual I*, the fee schedules are essentially read out of the statute, because whatever amount a provider charges is deemed "reasonable." *Virtual I* essentially re-defined 80 percent of reasonable expenses, as required under subsection (1)(a), to mean "**80% of the amount billed**." *Virtual I*, 79 So.3d at 57 (emphasis added). Defining "reasonable expenses" as the "amount billed" renders subsection (5)(a)2 meaningless – *i.e.*, insurers can never use the statutory

[7] As a matter of law, the Legislature would not authorize -- indeed, could not have authorized -- provider reimbursements at less than reasonable rates, *i.e.*, an amount less than 80% of reasonable medical expenses. *See MRI Assoc. of St. Pete, Inc. v. State Farm Mut. Auto Ins. Co.*, 755 F. Supp.2d 1205, 1208 (M.D. Fla. 2010) (rejecting "two methodology" argument "because it assumes the amount provided by the fee schedule is not reasonable").

fee schedules whether incorporated in a policy or not.[8] As discussed above, subsection (1)(a) specifies the mandatory minimum coverage required by the PIP statute. Applying the rationale that subsections (1)(a) and (5)(a)2 constitute two irreconcilable payment methodologies, any provider reimbursement under the fee schedules in subsection 5(a)2 *ipso facto* violates the coverage requirement of (1)(a). In other words, the statutory fee schedule provisions are rendered meaningless, which cannot have been the Legislature's intent.

### C. The Fee Schedule Opinions Undermine Legislative Intent by Enriching Providers at the Expense of Insureds.

In rendering *Virtual I*, the court was guided in significant part by *Kingsway*, which in turn followed *State Farm Fla. Ins. Co. v. Nichols*, 21 So.3d 904 (Fla. 5th DCA 2009). Importantly, *Nichols* did not involve PIP insurance, but was a sinkhole case involving homeowners' insurance. Nonetheless, *Kingsway* cites *Nichols* for the allegedly controlling principle that "when the insurance policy

[8] At least one court has so held. *See Amer. Indep. Ins. Co. v. Gables Ins. Recovery Inc.*, Case No. 10-346 AP (11th Cir. Ct. App. Div. Oct. 12, 2011) (policy which complied with the statutory mandate to provide coverage for 80% of reasonable medical expenses **and** stated that insurer would limit provider reimbursements consistent with Fla. Stat. §627.736(5)(a)2.f was deemed ambiguous, such that insurer could not limit reimbursement per fee schedules and was required to reimburse MRI provider the "higher amount" (*i.e.*, the billed amount); *see also USAA Cas. Co. v. DPI of N. Broward*, FLWSUPP 1911NEGR, Case No. 11-10404CACE(03) (17th Cir. Ct. App. Div. May 15, 2012) ("even if…section 627.736(5)(a)(2) is incorporated to the policy, the resulting ambiguity…supports the conclusion that USAA was obligated to pay DPI the greatest amount possible…."), citing *Virtual I.*

provides **greater coverage** than the amount required by statute, the terms of the policy will control." *Kingsway*, 63 So.2d at 68 (emphasis added). *Virtual I* concluded that incorporation of the fee schedules to PIP policies created ambiguities which, under traditional common law insurance principles, had to be "resolved in favor of the insured." *Virtual I*, 79 So.3d at 58; *see also DCI*, 79 So.3d at 842-843 (same).

The courts were, in essence, attempting to follow traditional common law principles of construing insurance policies favorably to insureds. However, because PIP insurance is statutorily mandated, it is "markedly different from homeowner's/tenants insurance, property insurance, life insurance, and fire insurance, which are not subject to statutory parameters and are simply a matter of contract…." *Custer Med. Ctr. v. United Auto. Ins. Co.*, 62 So.3d 1086, 1089 n.1 (Fla. 2011). In their misguided effort to 'do the right thing' for insureds by applying common law construction principles in this statutory setting, the *Kingsway, Virtual I* and *DCI* courts achieved precisely the opposite result.

Underlying each of these decisions is the assumption that paying a medical provider 80 percent of the amount billed provides "greater coverage" for insureds than does limiting provider reimbursements under the fee schedules. This is simply not so. Reimbursing PIP providers at reduced rates **benefits insureds**:

> [P]aying certain providers at PPO rates ha[s] in no way adversely affected the services available to the

> insureds.…**since each treatment provided by a PPO provider costs the insurer less than the same treatment given by a non-PPO provider, *more services* will be available to the insured within the $10,000 PIP policy limits** provided for in section 627.736(1).

*Jewell*, 862 So.2d at 86 (italics in original, bold type added); *see also Virtual II*, 90 So.3d at 327 (maximizing payments to providers "adversely affects insureds by more rapidly depleting their $10,000 coverage limit.") (Rothenberg, J., concurring).[9] Insureds are additionally protected when an insurer limits payment under the fee schedules, because the provider may not 'balance bill' the insured. *See* Fla. Stat. § 627.736(5)(a)5(2008) (renumbered by the 2012 Amendments as § 627.736(5)a.4.). As Judge Rothenberg opined, given this balance billing prohibition, "interpreting PIP insurance policies in favor of insureds actually

[9] In a revealing statement, the *Virtual I* majority remarked that although suit was brought by the provider, not the insured, the difference was "immaterial." *Virtual I*, 79 So.3d at 58 n.1. Because the provider as assignee "stands in the shoes" of the insured, the majority reasoned that the "benefit of the interpretation [of policies to favor insureds] flows to" the provider. *Id*. at n.2. The conclusion that providers are indistinguishable from insureds in this statutory setting ignores the functional reality that insureds and providers have adverse interests. Providers as assignees are certainly entitled to no more than insureds, so requiring insurers to pay providers in a way that accelerates depletion of the insureds' benefits and increases their out-of-pocket costs is wholly inconsistent with an interpretation ostensibly designed to protect insureds. It also violates the principle that where an insurance contract is susceptible of more than one reasonable interpretation, courts should "adopt[] the reasonable interpretation…that provides coverage as opposed to the reasonable interpretation that would limit coverage." *State Farm Mut. Auto. Ins. Co. v. Menendez*, 70 So.3d 566, 570 (Fla. 2011) (citations omitted).

requires reading the policies to cover the **lowest** amount possible." *Virtual II*, 90 So.3d at 327 (emphasis in original).

As illustrated in the summary of argument above, limiting provider reimbursements in accord with the fee schedules preserves insureds' limited PIP benefits and limits their out-of-pocket expenses; it also shelters insureds from balance billing. Thus, contrary to the holdings of the Fee Schedule Opinions, limiting provider reimbursements results in accord with the fee schedules results in "greater coverage" than does paying providers the "highest amount possible" under PIP policies. Insurers must be allowed to use the fee schedules to accomplish the Legislature's goal of providing broad PIP coverage for Florida motorists. *Blish v. Atlanta Cas. Co.*, 736 So.2d 1151 (Fla. 1999). The Fee Schedule Opinions require insurers to pay providers amounts higher than those authorized by the Legislature, to the immediate and meaningful detriment of insureds themselves, which contradicts the unambiguous statutory language, destroys the Legislature's intent and diverges from this Court's holding in *Holy Cross.*

## CONCLUSION

For each and all of the foregoing reasons, GEICO respectfully requests that this Court answer the certified question in the affirmative, quash the decision in *Virtual II* and disapprove the Fee Schedule Opinions.

Respectfully submitted,

**Shutts & Bowen LLP**
*Counsel for Petitioner*
4301 W. Boy Scout Blvd., Ste. 300
Tampa, Florida 33607
Telephone: (813) 227-8113
Facsimile: (813) 227-8213

- and -

1500 Miami Center
201 S. Biscayne Blvd
Miami, Florida 33131
Telephone: (305) 379-9121
Facsimile: (305) 415-9841

By: /s/ Suzanne Youmans Labrit
Frank A. Zacherl
Florida Bar No. 868094
*fzacherl@shutts.com*
Suzanne Youmans Labrit
Florida Bar No. 661104
*slabrit@shutts.com*
Jerel C. Dawson
Florida Bar No. 0152390
*jdawson@shutts.com*

## CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was served this 12th day of September, 2012 via email and U.S. Mail to the following:

**Harley N. Kane, Esq.**
**Joseph R. Littman, Esq.**
The Greenspan Law Firm, P.A.
4800 N. Federal Highway, Suite 101 E
Boca Raton, Florida 33431
servicebyemail@greenspanlawfirm.com
*Counsel for Respondent*

**Raoul G. Cantero, Esq.**
White & Case LLP
Southeast Financial Center, Suite 4900
200 S. Biscayne Boulevard
Miami, Florida 33131
Raoul.cantero@whitecase.com
*Counsel for Amici AIA and PCI*

**John R. Beranek, Esq.**
Ausley & McMullen
Post Office Box 391
Tallahassee, Florida 32302
jberanek@ausley.com
*Counsel for Respondent*

**Cynthia S. Tunnicliff, Esq.**
**Gerald Don Nelson Bryant IV, Esq.**
Pennington, Moore, et. al
215 South Monroe Street, Second Floor (32301)
Tallahassee, Florida 32302-2095
cynthia@penningtonlaw.com
*Counsel for Amicus Fla. Justice Reform Institute*

**Nancy Wallace, Esq.**
Akerman Senterfitt
106 E. College Ave., Suite 1200
Tallahassee, Florida 32301
nancy.wallace@akerman.com
*Counsel for Amici PIFF and NAMIC*

/s/ Suzanne Youmans Labrit
Suzanne Youmans Labrit

## CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with Florida Rule of Appellate Procedure 9.210(a)(2) because it was prepared using Times New Roman 14-point font.

/s/ Suzanne Youmans Labrit
Suzanne Youmans Labrit

TPADOCS 19568731 1