**IN THE SUPREME COURT OF FLORIDA**

**CASE NO.: SC15-2298**

L.T. CASE NO.: 4D14-287

ALLSTATE INSURANCE COMPANY,

Petitioner,

v.

ORTHOPEDIC SPECIALISTS a/a/o Kelli Serridge,

Respondent.

On Review from the District Court of Appeal, Fourth District, State of Florida

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# PETITIONER'S REPLY BRIEF

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## PREFACE

Petitioner Allstate Insurance Company is called "Allstate." Respondent Orthopedic Specialists, as assignee of Kelli Serridge, is called "the Provider." Unless otherwise indicated, citations to the Florida Motor Vehicle No-Fault Law (§§ 627.730-.7405, Fla. Stat.) are to the 2009 version of the statute, which was in effect on the date of claimed loss and is cited in the decision on review. All emphasis in quoted material is in the original unless otherwise noted. References to the Initial Brief appear as "IB" and references to the Answer Brief appear as "AB".

The decision on review is *Orthopedic Specialists a/a/o Serridge v. Allstate Insurance Co.*, 177 So. 3d 19 (Fla. 4th DCA 2015) ("*Serridge*"). Allstate invoked this Court's jurisdiction upon the Fourth DCA's certification of conflict with *Allstate Fire & Cas. Ins. Co. v. Stand-Up MRI of Tallahassee, P.A.*, No. 1D14-1213, 2015 WL 1223701 (Fla. 1st DCA Mar. 18, 2015), *pet. pending*, No. SC15-962 ("*Stand-Up*"). The Second DCA recently issued an opinion on the same issue as *Serridge* and *Stand-Up,* sided with the *Stand-Up* decision, and certified conflict with *Serridge*. *Allstate Indem. Co. v. Markley Chiro. & Acupuncture, LLC a/a/o Chavez*, No. 2D14-3818, 2016 WL 1238533 (Fla. 2d DCA March 30, 2016), *mot. for reh'g and reh'g en banc pending* ("*Markley*").

## ARGUMENT

### I. THE PROVIDER'S ARGUMENTS ARE PREDICATED ON CRITICAL LEGAL ERRORS IN THE *SERRIDGE* MAJORITY OPINION.

In *Virtual III*[1], this Court held "that under the 2008 amendments to the PIP statute, a PIP insurer cannot take advantage of the Medicare fee schedules to limit reimbursements without notifying its insured by electing those fee schedules in its policy." 141 So. 3d at 160. In *Stand-Up* and *Markley*, two unanimous DCA panels held that Allstate's policy provides such notice; in *Serridge*, two judges concluded otherwise in two different opinions. Dismissing *Stand-Up* as "clear error" (AB at 4), the Provider premises its arguments on basic errors of law committed by the *Serridge* majority. The Provider's arguments should be rejected in their entirety as their foundation is demonstrably legally erroneous.

#### A. *Virtual III* Confirms That Insurers Cannot Disclaim the "Basic Coverage Mandate."

One way or another, the Provider's arguments all are rooted in the *Serridge* majority's holding that an insurer's notice must "make it inescapably discernible that it will not pay the 'basic' statutorily required coverage and will instead substitute the Medicare fee schedules as the exclusive form of reimbursement." *Serridge*, 177 So. 3d at 26; *see also id*. at 24 (Allstate's policy "fails to state . . .

[1] *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc*., 141 So. 3d 147 (Fla. 2013) ("*Virtual III*" or "*Virtual Imaging*").

that Allstate will not pay 80% of reasonable charges and will actually limit payment to FS 627.736(5)(a)(2)(a-f).") (citation omitted). For instance, the Provider states "[t]he only sure way to [give notice required by *Virtual III*] is to say . . . that the insurer will not actually pay 80% of reasonable charges and instead that it will calculate benefits only under the permissive Medicare fee schedules." AB at 12. This contention permeates the entire brief. *See id*. at 7-8 (policy is ambiguous if it provides coverage for 80% of reasonable medical expenses **and** limits provider payments per fee schedules); *id*. at 14-15 (provision stating that policy will pay 80% of reasonable medical expenses "contradict[s]" provision stating that payments "shall be" subject to payment limitations); *id*. at 21 (policy specifies different methods for calculating benefits without electing either "exclusively").

*Virtual III* wholly negates the *Serridge* majority's holding and the Provider's arguments based thereon in two different ways. **First**, *Virtual III* explicitly confirms the "basic coverage mandate" that "**every PIP insurer is required to—that is, the insurer 'shall'—reimburse eighty percent of reasonable expenses** for medically necessary services." 141 So. 3d at 155 (emphasis added). **Second**, this Court rephrased the certified question in *Virtual III* expressly to clarify that the "specific legal issue" is "not whether an insurer can compute reimbursements based on the Medicare fee schedules '*rather than*' provide 'reasonable medical

expenses' coverage, as the question certified by the Third District frames the issue." *Id*. at 150 n.3. This Court emphasized that the "very reason" it rephrased the question was it did "**not** conclude that limiting reimbursement pursuant to section 627.736(5)(a)2. would never satisfy [the] reasonable medical expenses coverage mandate." *Id*. at 157 n.8.[2] However, the *Serridge* majority and the Provider ignore the rephrasing and the clarifications it represents.

By confirming the "basic coverage mandate" and then explaining (not once but twice) that the certified question was rephrased to recognize compatibility of the basic coverage mandate with statutorily authorized payment limitations, this Court confirmed that an insurer electing to use those limitations is not (indeed, cannot be) required to disclaim the statutory mandate to provide coverage for eighty percent of reasonable medical expenses. And no other authority supports the proposition that the PIP statute authorizes insurers to reject this "basic coverage mandate." Accordingly, the *Serridge* majority's holding—and the Provider's various arguments constructed upon it—that Allstate's policy is ambiguous because it does not disclaim the "basic coverage mandate" directly contradict

[2] This Court rephrases certified questions "[t]o clarify the issue presented," *State Farm Mut. Auto. Ins. Co. v. Roach*, 945 So. 2d 1160, 1162 (Fla. 2006), "to conform them more properly to the true issue under review," *Gracey v. Eaker*, 837 So. 2d 348, 351 n.1 (Fla. 2002), "to more accurately reflect the issue presented," *State v. Merricks*, 831 So. 2d 156, 158 (Fla. 2002), or to "emphasize the significance" of a certain concept. *Tiara Condo. Ass'n, Inc. v. Marsh & McLennan Cos.*, 110 So. 3d 399, 412 (Fla. 2013) (Canady, J., dissenting).

*Virtual III* and should be rejected.

### B. *Serridge*'s Requirement That Insurers "Exclusively" Elect "Medicare Fee Schedules" Contradicts the Statutory Text.

Invoking another critical legal error in *Serridge*, the Provider complains Allstate's notice is ambiguous because it does not elect the Medicare fee schedules "exclusively." AB at 19-21; *Serridge*, 177 So. 3d at 25-26 (notice is deficient "unless it plainly and obviously limits reimbursement to the Medicare fee schedules exclusively"). The Provider overlooks—as did the *Serridge* majority—that the payment limitation criteria in section 627.736(5)(a)2. are not "exclusively" Medicare fee schedules and include several other criteria. *See* § 627.736(5)(a)2.b. (hospital emergency services limited to 75% of "usual and customary"); § 627.736(5)(a)2.c. (physician and dentist reimbursements limited to "usual and customary"); § 627.736(5)(a)2.f. (payments for services not reimbursable under Medicare Part B may be limited per workers' compensation statute).

By stating that amounts payable "shall be subject to any and all limitations, authorized by section 627.736 . . . including, but not limited to, all fee schedules," Allstate's policy gives unambiguous notice that **all** statutorily authorized limitations—including the Medicare fee schedules where applicable—will be used. Accepting the *Serridge* majority's conclusion—and the Provider's argument—that Allstate must limit reimbursements "exclusively" to some but not all criteria identified in section 627.736(5)(a)2. would contradict the statutory text. That text

plainly states the Legislature's authorization that insurers "may limit reimbursement" to "the following schedule of maximum charges" which includes but is not limited to the Medicare fee schedules. *Id*.

## II. *STAND-UP* AND *MARKLEY* CORRECTLY HELD THAT "SIMPLE NOTICE" IS SUFFICIENT UNDER *VIRTUAL III*.

The Provider quarrels with the First DCA's "simple notice" holding in *Stand-Up* (which the Second DCA adopted in *Markley*), insisting *Virtual III* requires something more than policy-based notice of an election to use the limitations authorized by section 627.536(5)(a)2. AB at 8-9. The Provider's arguments on this point are a variation on the recurring (and legally flawed) themes that Allstate's policy is ambiguous because it does not disclaim the basic coverage mandate and "exclusively" elect the Medicare fee schedules. *See* AB at 7 (policy is ambiguous since it does not specify "that the Medicare fee schedules will be the only method to calculate benefits"); *id*. at 7-8 (policy is ambiguous if it provides coverage for 80% of reasonable expenses **and** includes reimbursement limitations). As established above, *Virtual III* and the statutory text wholly negate these arguments, so they warrant no further discussion. Furthermore, a "simple notice" requirement is eminently practical. As *Virtual III* notes, the Legislature amends the PIP statute frequently. 141 So. 2d at 152. Every new amendment would force insurers to change policy forms if a highly specific notice were required.

### A. The Provider's *Stare Decisis* Argument Is Meritless.

The Provider claims *Stand-Up*'s "simple election" holding "is patently in conflict" with this Court's prior decisions. AB at 9. According to the Provider, a holding that *Stand-Up* was correctly decided "would present a formidable problem of *stare decisis* with decisions holding 'many times' that utter clarity in policy language is required to limit benefits." *Id*. at 9-10. Borrowing the Provider's word, this argument is "preposterous." *Id*. at 21. This Court has **never** adopted an "utter clarity" standard for policy construction and has never held that any such standard applies to PIP policy language notifying insureds that medical provider payments shall be subject to statutorily authorized limitations. But even if that were to become the standard, the simple notice Allstate provided is utterly clear—in stark contrast to the convoluted, legally flawed notice the Provider apparently would prefer.

The Provider also chastises Allstate for not citing *Ruderman*,[3] implying *Ruderman* specifically applies to the instant case. AB at 5, 20 n.26. It does not. The *Ruderman* plurality held that coverage provisions in a home healthcare policy were ambiguous and should be construed against the insurer and in favor of coverage without resort to extrinsic evidence. The instant case involves PIP, not home healthcare, and presents no question about resorting to extrinsic evidence.

[3] *Washington Nat'l Ins. Co. v. Ruderman*, 117 So. 3d 943 (Fla. 2013).

*Ruderman* is relevant only insofar as it recites general principles of policy construction, and Allstate relied on the same authorities as *Ruderman* for those principles. *Compare* Initial Brief at 17-20 with *Ruderman*, 117 So. 3d at 949-951 (both discussing *Menendez, J.S.U.B.*, *Swire*, *Pridgen* and *Excelsior*).

The "simple election" requirement recognized in *Stand-Up* (and more recently in *Markley*) is not inconsistent with any prior holding of this Court, let alone "an express prior holding from this Court on [the] specific issue"[4] presented in this case: whether Allstate's policy language is legally sufficient to comply with the notice requirement this Court announced in *Virtual III*. In short, the Provider's *stare decisis* argument is—using the Provider's lexicon (AB at 20)—"nonsense."

### B. *Virtual III* Does Not Require A "Specific Election."

The Provider argues a notice is unambiguous only if it **specifically** elects "the Medicare fee schedules [as] the **only** method to calculate benefits." AB at 7 (emphasis added). As a threshold matter, this theory is legally wrong for the reasons discussed above. Beyond that, by rephrasing the certified question in *Virtual III*, this Court confirmed that no "specific election" is required. The question the Third DCA certified was whether insurers could "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**…."

[4] AB at 9 (quoting *Puryear v. State*, 810 So. 2d 901, 905 (Fla. 2002)).

*Virtual III*, 141 So. 3d at 149 n.2 (emphasis added). This Court deleted the reference to "specifically electing" and changed the question to whether an insurer can limit reimbursements "without providing **notice in its policy of an election to use** the Medicare fee schedules." *Id*. at 150 (emphasis added).[5] *Virtual III* thus clarified that it did not impose a "specific election" requirement and held that insurers may use the limitations in section 627.736(5)(a)2. if policy-based notice of an election to do so is provided. *Id*. at 159, 160; *see also Markley*, at * 3 (rejecting trial court's conclusion that *Virtual III* "require[s] an express and specific election of the Medicare fee schedules or section 627.736(5)(a)(2)-(5)").

In summary, Allstate respectfully submits the First and Second Districts correctly concluded—and this Court should confirm—that "*Virtual Imaging* did not dictate a form of notice" (*Markley*, at * 4) and "requires no other magic words. . . . [I]ts simple notice requirement is satisfied by Allstate's language limiting '[a]ny amounts payable' to the fee schedule-based limitations found in the statute." *Stand-Up*, at * 2. *See also S. Fla. Wellness, Inc. v. Allstate Ins. Co.*, 89

[5] Like this case, *Virtual III* involved reimbursements for diagnostic imaging services, which fall under subsection 627.736(5)(a)2.f. That subsection authorizes payments to be limited to "200 percent of the allowable amount under the participating physicians schedule of Medicare Part B." *Id*. *Virtual III*'s reference to "Medicare fee schedules" appears based on the specific services and reimbursements at issue in that case; it would make no sense to require a "specific" or "exclusive" election of "Medicare fee schedules" when three other subsections of 627.536(5)(a)2. authorize limitations based on criteria **other than** Medicare fee schedules. *See* discussion in section I(B) above.

F. Supp. 3d 1338, 1341 (S.D. Fla. 2015) (acknowledging import of rephrased certified question and concluding that *Virtual III* requires a "mere election to use fee schedules").[6]

## III. THE PHRASE "SHALL BE SUBJECT TO" IS NOT AMBIGUOUS.

*Virtual III* requires policy-based notice that medical provider payments will be limited in accordance with section 627.736(5)(a)2. As the First and Second Districts correctly held, Allstate did just that and nothing in its notice is in any way ambiguous.[7] Nonetheless, the Provider devotes ten footnote-rich, block-quote intensive pages to a meandering dissertation on how "almost any use of shall" creates "ambiguity" and why "subject to" can be interpreted as having "several commonly accepted contradictory meanings in general, popular usage." AB at 13,

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[6] Allstate has never characterized *Virtual III*'s observation that GEICO's amended policy "included an election of the Medicare fee schedules" (141 So. 3d at 150) as anything other than *dicta*. Although the Provider disagrees (AB at 21-23), it was indisputably proper for the First DCA and District Judge Dimitrouleas to consider this Court's *dicta* as persuasive. *See* cases discussed in IB at 9 n.2. The Provider's suggestion that this reference only limits the temporal reach of this Court's ruling is unfounded because it was unnecessary to mention GEICO's amended policy language to explain that the holding of *Virtual III* was limited to policies issued after the 2008 amendments and before the effective date of the 2012 amendments to the PIP statute.

[7] Although the Provider suggests otherwise (AB at 1), the fact that Allstate's notice is in an endorsement does not render it ambiguous or affect its legal sufficiency. "Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy **and as amplified, extended, or modified by** any application therefor or **any** rider or **endorsement thereto**." § 627.419(1), Fla. Stat. (2009) (emphasis added).

17. The Provider's assault on Allstate's language is an improper attempt to isolate words and phrases and misinterpret them in a context-free setting. In other words, the Provider "atomizes one issue into protons and neutrons of many issues." AB at 4 n.7.

### A. There Is No Reason To Disregard The Plain Meaning Of "Shall."

The Provider never challenges that Florida precedent—including this Court's discussion in *Virtual III*—establishes beyond debate that the normal, usual and common understanding of the word "shall" is that it is mandatory in nature. Indeed, the Provider concedes as much: "Often…'shall' is mandatory." AB at 15 (quoting Bryan Garner). And the Provider presents no justification to disregard the ordinary understanding that "[m]andatory words impose a duty. . . .The traditional, commonly repeated rule is that *shall* is mandatory . . . when the word *shall* can reasonably be read as mandatory, it ought to be so read." Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts*, § 11 at 112, 114 (2012 ed.).

Reduced to its essence, the Provider's argument is that "shall" is not properly used when it is intended to mean something other than "has a duty to." AB at 15. Allstate agrees, as do the vast majority of legal commentators. *See, e.g.*, *Reading Law: The Interpretation of Legal Texts*, § 11 at 112 ("shall" ought to be synonymous with "has a duty to" or "is required to"). In Allstate's policy, that is

precisely what "shall" means. Regardless of whether "shall" is an "adverbial imperative" (AB at 15), its use is straightforward and involves no unusual meaning: it **mandates** that amounts payable are "subject to" the statutorily authorized payment limitations. Given its traditional and ordinary meaning, "shall" means Allstate "has a duty to" or "is required to" apply the limitations. *See Virtual III*, 141 So. 3d at 155 ("**every PIP insurer <u>is required to</u>—that is, the insurer '<u>shall</u>'**. . . .") (emphasis added). In short, ascribing a different meaning to "shall" as used here would eviscerate decades of precedent and usage.

Finally, the Provider's attack on "shall" again hinges on its unsupportable claim that insurers must disclaim the basic coverage mandate. The Provider concedes it is "not at all unreasonable to read [Allstate's language], not as an imperative at all, but instead to state a simple future promise," and then asserts that interpretation must be rejected because "*both* future promises ['will pay reasonable' and 'shall be subject to…limitations'] cannot be kept." AB at 14. But as we know from *Virtual III*, the two undertakings most certainly are compatible.

### B. As Written, And In Context, "Subject To" Means "Governed Or Affected By" And Is Not Ambiguous.

The Provider does not dispute that "subject to" has a meaning—"governed or affected by"—that is unambiguous and appropriate in this context. *See* IB at 31. And the Provider does not dispute that context aids in determining the meaning of

a word with several dictionary meanings. *Id.* at 30.[8] Importantly, the Provider also does not dispute that "subject to" uniformly means "governed or affected by" in the context of insurance policies. *Id.*

The Provider argues "subject to" is ambiguous because it has several dictionary definitions, but concedes that ambiguity arises only if there is "more than one reasonable interpretation." AB at 18. The Provider proffers no reasonable interpretation of "subject to" that conflicts with "governed or affected by" in the context Allstate used the language. Instead, the Provider suggests Allstate's language "reserve[d] discretion *possibly* to reimburse under any fee schedule in the statute." *Id*. But when the term "subject to" is read with the immediately preceding words ("amounts payable under this coverage shall be subject to any and all limitations"), there is no suggestion of discretion or

[8] *See also State Farm Mut. Auto. Ins. Co. v. Pridgen*, 498 So. 2d 1245, 1248-49 (Fla. 1986) (terms of an exclusion which might otherwise seem unclear are not ambiguous where context clarifies meaning); *Cap. Nat'l Fin. Corp. v. Dep't of Ins. & Treas.*, 690 So. 2d 1335, 1336-37 (Fla. 3d DCA 1997) ("In prohibiting certain activities of a finance company in a finance agreement, it is clear that the ordinary and plain meaning of the term 'financing' **as it is used in that context** is the advancement of money rather than the mere collection of funds") (emphasis added); *Taylor v. United Servs. Auto. Ass'n*, 684 So. 2d 890, 895 (Fla. 5th DCA 1996) ("the word 'resident' has many different meanings in law, and the one most applicable is largely determined by the statutory context in which that term is used"); *Hancock Advert., Inc. v. Dep't of Transp.*, 549 So. 2d 1086, 1088 and n.4 (Fla. 3d DCA 1989) (construing "on," which has at least forty-three dictionary definitions depending on the context in which it is used), *superseded by statute* as stated in *Republic Media, Inc. v. Dep't of Transp*., 714 So. 2d 1203, 1204 (Fla. 5th DCA 1998).

"possibility" because Allstate's undertaking to subject amounts payable to limitations is plainly **mandatory**.

Attempting to avoid the plain meaning of "shall be subject to," the Provider again argues ambiguity exists absent a disclaimer of the basic coverage mandate and an "exclusive" election of the Medicare fee schedules. AB at 19-21. In this iteration of its now-familiar mantra, the Provider claims Allstate's notice "refers to both the non-Medicare fee schedules in (5)(a)1 (the original required benefit paying 80% of any reasonable charge...), and the Medicare fee schedules listed in (5)(a)2.a, d, e and f (the alternative benefit calculation)." *Id*. at 21.

Emphatically, Allstate's notice that "**amounts payable** shall be **subject to**...**limitations**, authorized by section 627.736" does **not**—and cannot be interpreted to—refer to the "fee schedules" mentioned in subsection (5)(a)1. because that statutory provision authorizes **no** "limitations" on provider reimbursements or benefits payments. By its express terms, subsection (5)(a)1. applies **not** to **insurer payments**, but only to **provider charges**: "Any physician, hospital, clinic. . .**may charge** the insurer and injured party only a reasonable amount. . . ." *Id*. (emphasis added); the provision then specifies criteria (including fee schedules) that may be considered in determining the reasonableness of a **charge**. The only limitations applicable to insurer payments are in subsection 5(a)2., which states that "[t]he **insurer may limit reimbursement** to 80 percent of

the following schedule of maximum charges:" *Id*. (emphasis added); *see also S. Fla. Wellness*, 89 F. Supp. 3d at 1341 (rejecting contention that subsection 5(a)1. is a limitation on reimbursement and noting that it "directs ***providers***, not insurers, to charge reasonable rates") (italics in original; bolding added).

### C. Statutory Reimbursement Limitations Promote Legislative Policy And Support "Insured-Favorable" Construction of Any Ambiguity.

The statutorily authorized reimbursement limitations promote the Legislature's policy decision to "regulate the amount providers could charge PIP insurers and policyholders for the medically necessary services PIP insurers are required to reimburse." *Virtual III*, 141 So. 3d at 153. The Provider's contention that "undesirable consequences" might result because "fewer providers accept the lower Medicare rates" (AB at 25-26) altogether lacks record support and is a misdirected complaint against the Legislature's policy decision. *See also Serridge*, 177 So. 3d at 30 ("While some providers may choose to not treat an insured if their fee is limited to the Medicare fee schedules, that problem is one of the provider's making, not that of the insurer.") (May, J., dissenting).

Moreover, the Provider is not entitled to an 'insured-favorable' construction. The Provider only has an assignment of benefits—the right to receive payment of policy benefits due to the insured—not an assignment of the entire policy. The insured remains the policy owner. Accordingly, an assignment of benefits does not

place the provider in "the shoes of the insured" to permit an interpretation detrimental to the insured. *See Bioscience W., Inc. v. Gulfstream Prop. & Cas. Ins. Co.*, 185 So. 3d 638, 641 (Fla. 2d DCA 2016) (assignment of "insurance rights, benefits and proceeds pertaining to services provided" was not assignment of entire policy). Because Allstate's election notice is not ambiguous, it is unnecessary to result to rules of construction. But if such rules are applied, any interpretation should advance public policy, which here requires a construction in favor of the insured and against the Provider.

## CONCLUSION

Policy language is ambiguous only if it is susceptible of more than one **reasonable** interpretation. *Penzer v. Transp. Ins. Co*., 29 So. 3d 1000, 1005 (Fla. 2010). In *Stand-Up* and *Markley*, the First and Second DCAs held that Allstate's policy is reasonably interpreted to provide notice of Allstate's election to limit provider reimbursements in accordance with the statutory fee schedules. Neither the *Serridge* majority nor the Provider offer any alternate reasonable interpretation.

For each and all of the foregoing reasons, as well as those discussed in Allstate's Initial Brief, this Court should reaffirm its holding in *Virtual III* by approving the decisions of the First DCA in *Stand-Up* and the Second DCA in *Markley* and quashing the contrary decision of the Fourth DCA in *Serridge*.

Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE

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

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