Recent PIP Decisions

1. **Nationwide v. AFO Imaging, Inc. (Fla. 2DCA 2011)** –

    a. In this case the insurance company argued that they were entitled to pay for nonemergency, nonhospital MRI services based on Medicare's Hospital Outpatient Prospective Payment System ("OPPS") because this amount was part of the participating physicians Medicare Part B fee schedule and served as an allowable limitation on the amounts recoverable.

    b. The 2nd DCA rejected this argument and reasoned that § 627.736(5)(a)(2)(f) and (5)(a)(3) "unambiguously refer to the participating physicians schedule of Medicare Part B as the schedule upon which to rely." The Court further reasoned that the fee schedule amount payable by Medicare under OPPS is a separate and distinct component of Medicare Part B.

    c. The 2nd DCA held that since the applicable statute is unambiguous and refers only to Medicare Part B's participating physicians' schedule, the minimum amount due for MRI services provided in a nonemergency, nonhospital setting cannot be capped by the OPPS.

2. **Kingsway Amigo v. Ocean Health, Inc. (Fla. 4DCA 2011)** –

    a. The issue in this case was whether a PIP insurer may choose to use the Medicare Part B fee schedules set forth in the statute even when the underlying insurance policy specifies that the PIP insurer will pay 80% of medically necessary expenses.

    b. The 4th DCA, realizing that 80% of 200% of the Medicare Part B fee schedule was less than 80% of the billed amount, held that they cannot.

    c. The 4th DCA reasoned that the statute is unambiguous and that the plain language allows an insurer to choose between the two different payment calculation methodology options. However, the PIP policy must specify which payment methodology it chooses.

3. **Geico v. Physicians Group (Fla. 2DCA 2010)** –

    a. The 2nd DCA held that the 2008 version of § 627.736 does not apply retroactively. The statute in effect at the time an insurance contract is executed governs substantive issues arising in connection with that contract.

4. **United v. Palm Chiropractic Center, Inc. (Fla. 4DCA 2010)** –

   a. In this case, United petitioned the 4th DCA for a writ of certiorari to quash an order by the circuit court, in its appellate capacity, affirming the county court's grant of final summary judgment in favor of Palm Chiropractic Center (i.e., a second tier certiorari).

   b. This case centers on Palm Chiropractic Center cashing a check that contained the notation: "Pay to the order of PALM CHIROPRACTIC CTR FOR FULL & FINAL PAYMENT OF PIP BENEFITS."

      i. United argued that Palm's acceptance of the check constituted an accord and satisfaction.

      ii. Palm Chiro argued that the accepted check did not constitute an accord and satisfaction and it was merely a partial payment for services rendered.

   c. The 4th DCA held that mere legal error is not a departure from the essential requirements of law remediable in a second tier certiorari. The Court denied United's petition for writ of certiorari.

   d. In dicta, the 4th DCA stated that "the circuit court incorrectly applied the correct law." The court further stated, in dicta, that cashing a check containing language that it is full payment creates an accord and satisfaction. Since this statement by the Court did not directly control the outcome of the case and is therefore dicta, its precedential value is questionable.

5. **Shaw v. State Farm Fire and Casualty Company (Fla. 5DCA 2010)** –

   a. The issue in this case was whether an EUO clause in an automobile insurance policy is binding on an assignee (medical provider) of the right to payment of no-fault benefits.

   b. The 5th DCA held that assignee medical providers are not required to attend EUO's.

   c. The 5th DCA reasoned that the assignee (medical provider) of the right of the insured to payment under the insurance contract has no duty to perform any covenant under the insurance contract because the assignee (medical provider) never agreed to do so.

   d. The Court reasoned that the medical provider merely agreed to accept an assignment of the amount due under the policy; he did not agree to undertake any duties under the policy.

6. **MRI Associates of America v. State Farm Fire and Casualty Company (Fla. 4DCA 2011)** –

   a. In this case the medical provider submitted its medical record and a HICF to the insurance company seeking a total of $3,523.50 ($1,707.33 for one MRI and $1,816.17 for the other). The insurance company then hired an expert to conduct a "paper peer review" and subsequently denied the claim based on that review. The medical provider then submitted a pre-suit demand letter with the same exact amounts billed in the HICF, but also included an additional column labeled "Amount in Dispute if Paid at 80%". The insurance company declined to pay.

   b. The 4th DCA held that the pre-suit demand letter was sent prematurely because payment was not overdue since the medical provider did not provide the insurance company with proper notice of the exact amount owed.

   c. The Court reasoned that the HCFA failed to specify the exact amount owed under the statute and the amount billed exceeded what was allowed for the MRIs by the statute. The Court further reasoned that since the language in the statute requires precision in a demand letter by requiring an "itemized statement specifying each exact amount" and since the HCFA can be used as the itemized statement, it makes sense that the HCFA would have to comply with the same precision.

   d. "The statutory requirements surrounding a demand letter are significant, substantive preconditions to bringing a cause of action for PIP benefits." The demand letter is the foundation upon which the lawsuit is built.

7. **Custer Medical Center v. United (Fla. 2010)** –

   a. In this case, an injured passenger was treated by a medical provider who later sought to recover PIP benefits under an insurance policy. After the medical provider submitted a final bill to the insurance company, the insurance company attempted to schedule the injured passenger for a medical examination on two separate occasions. After the injured passenger failed to appear at both examinations, the insurance company suspended/denied PIP benefits.

   b. The Florida Supreme Court held that attendance at a medical examination is not a condition precedent to the coverage of an existing automobile insurance policy. The insurance company in this case was required to present evidence to the fact-finder that the insured unreasonably failed to attend a medical examination w/o explanation after having received proper notice. A failure to attend a medical examination is not automatically considered a "refusal" under the statute.

c. The Court reasoned that a dispute concerning attendance at a medical examination concerns the insured's right to receive subsequent benefits under the insurance policy; it does not dispute the existence of the policy.

d. The Custer opinion is also significant as follows:

   i. PIP policy provisions that are not directly consistent with the PIP statutes may be unenforceable.

   ii. Unless the statute expressly allows it, a PIP carrier may not deny payment of medical expenses that were incurred and submitted by the insured before an IME is scheduled, even if an insured does not attend the IME.

   iii. Unless the statute expressly allows it, a PIP carrier may only deny payment of an insured's medical expenses that were incurred and submitted by the insured after the date of the IME if the carrier can affirmatively prove that the insured's failure to attend the IME was unreasonable.

   iv. Since the Court pointed out that EUOs are not expressly allowed under the Florida PIP statutes, the denial of benefits based on an insured's failure to attend an EUO without counsel may no longer be valid.

8. **Sheldon v. United Services Automobile Association (Fla. 1DCA 2010)** –

a. The issue in this case was whether after PIP benefits are exhausted, is a plaintiff barred from filing or maintaining a previously filed lawsuit against an insurance company to pursue a claim solely for penalties, interest, and concomitant attorney's fees on benefits that were reduced or denied prior to the exhaustion of benefits.

b. The 1st DCA held that a plaintiff is barred from filing or maintaining a lawsuit solely to pursue penalties, interest, and attorney's fees after PIP benefits are exhausted.

c. The Court reasoned that once an insurer has paid out the policy limits it is not liable to pay any further PIP benefits, even those that are in dispute. If benefits are exhausted after suit is filed, but before the suit is served on the insurer, the suit for benefits may not go forward because the insurer has met its obligation under the contract.

9. **Pembroke Pines MRS v. Garrison Property and Casualty (Broward Cty. Court 2011) – Judge Zeller**

    a. Since the insurance company did not have reasonable proof that it was not responsible for the medical provider's claim when the medical provider put the insurance company on timely notice, the insurance company failed to timely pay PIP benefits required under § 627.736(4)(b). Since this occurred long before benefits were exhausted, the insurance company is liable despite the exhaustion of benefits.

10. **United Automobile Insurance Company v. Professional Medical Group, Inc. (Fla. 3rd DCA 2009)** –

    a. The failure of the medical provider to include the treating physician's license number in Box 31 is only a valid defense when the insurer can establish it did not know who the physician was or that the physician was unlicensed. The insurer must advise the medical provider that it does not know who the physician was or that the insurer believes the physician is unlicensed so that the provider can provide the physician's license number. Otherwise the defense is waived.

11. **USAA Casualty v. Pembroke Pines MRI (Fla. 4DCA 2010)** –

    a. An independent diagnostic corporate supplier of MRI services does not have to include the professional license number of either the interpreting radiologist or its medical director in box 31 of its CMS 1500 claim form to have furnished notice of the amount of covered loss or medical bills under section 627.736(5)(d), Florida Statutes.

12. **Florida Medical & Injury Center v. Progressive (Fla. 5th DCA 2010)** –

    a. The failure to provide a disclosure & acknowledgement form does not equate with the failure to receive notice of a covered loss.