IN THE CIRCUIT COURT OF THE
ELEVENTH JUDICIAL CIRCUIT
IN AND FOR MIAMI-DADE
COUNTY, FLORIDA

APPELLATE DIVISION

15-145 AP

14-5989 SP 25

USAA Casualty Insurance
Company,

Appellant,

v.

Health Diagnostics of
Fort Lauderdale, LLC

_____/

OPINION

Opinion filed:

On Appeal from the County Court in and for Miami-Dade County, Florida, Judge Gloria Gonzalez-Meyer.

Douglas H. Stein, Esq., for Appellant.
Julie H. Littky Rubin, Esq., and Martin I. Berger, for Appellee.

Before: LOURDES SIMON, CHARLES K. JOHNSON, AND OSCAR RODRIGUEZ-FONTS, JJ.

05/14/2018

CHARLES K. JOHNSON

5/14/18

Summary judgment was granted by the court below for the Appellee, Health Diagnostics of Fort Lauderdale, LLC, based upon the trial court construing USAA Casualty Insurance Company's post-suit payment as a confession of judgment.

Although it is not entirely clear from the record below when the explanation of review (EOR) was sent to Appellee, that EOR was printed on August 28, 2013.

It has not been contested that the EOR was sent prior to Appellee's demand letter, sent on October 29, 2013. That EOR requested additional information concerning documentation to support that the patient had an emergency medical condition (EMC).

Nor is it refuted that the Appellant sent a 6(b) request on December 9, 2013, again requesting information supporting that the patient had an EMC.

Appellee did not respond to this request, but rather filed suit on May 12, 2014, five months later.

Not until November 13, 2014, did the Appellee file an EMC affidavit, well over one year after such documentation was first requested, and six months after the lawsuit was filed. USAA paid the claim within six days after receiving the requested 6(b) information.

These circumstances do not constitute a confession of judgment. Under these unique facts, there has been no *wrongful* denial of benefits. The demand letter was premature, and USAA's payment was not overdue.

In *Progressive Ins. Co. v. Garrido,* 211 So. 3d 1086, 1093 (Fla. 3d DCA 2017), the Third District Court of Appeal clarified that Section 627.736(1)(a)3 expressly required an EMC diagnosis to trigger full 10,000 availability, holding that when no EMC diagnosis has been provided by an authorized medical provider, the available PIP medical benefits are limited to $2,500. That is exactly the amount previously paid out in this case, prior to the demand letter. No additional amount was due until such time as the EMC proof was provided.

We, however, can find no fault with the trial court's analysis of this emerging issue. At that time, the trial court did not have the benefit of Third DCA

case law directly on point. The court below rendered a decision in 2015; the Third District addressed this specific issue in February of 2017, nearly two years later.

Sitting in an appellate capacity, we have the advantage of Monday morning quarterbacking with binding case law firmly in hand. The trial court had no such luxury.

As such, we are compelled to reverse, and to remand for the trial court to grant summary judgment in favor of the Appellant.

REVERSED and **REMANDED** for proceedings consistent with this opinion.

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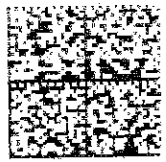

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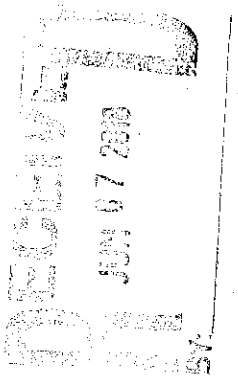

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