IN THE THIRTEENTH JUDICIAL CIRCUIT FOR THE STATE OF FLORIDA
Civil Appellate Division

PROGRESSIVE AMERICAN INSURANCE COMPANY,
Appellant,

Circuit Appeal number: 17-CA-10296
Division: X
Co. Ct. Case No.: 15-CC-16500

vs.

HESS SPINAL & MEDICAL CENTERS, INC.
a/a/o STEFAN ILIEV,
Appellee.
_____/

On review of a final judgment of the county court for
Hillsborough County, Florida.
The Honorable Michael Williams, County Court Judge.

ON MOTION FOR REHEARING

In light of the court's consideration of Appellee's Motion for Stay/Rehearing, the court denies the motion for stay/rehearing, withdraws the original opinion issued July 12, 2019, and substitutes the following in its place. The result is unchanged.

APPELLATE OPINION

This appeal seeks review of a final judgment entered against Progressive American Insurance Company (Progressive) on the first count of a two-count complaint for declaratory relief filed by Hess Spinal & Medical Centers (Hess). Hess sought relief based on an alleged underpayment by Progressive for medical services rendered to Progressive's insured after he was injured in a covered incident. Rather than seek damages, the complaint's first count for declaratory relief sought a declaration that the policy of insurance failed to clearly and unambiguously elect to reimburse the personal injury protection (PIP) claim in accordance with the fee schedules allowed by §627.736(5), Florida Statutes. The second count sought a declaration that Progressive's reliance on a coding policy known as MPPR (Multiple Procedure Payment Reduction) also violated the statute because it constituted a statutorily prohibited utilization limit. The judgment determined that the policy failed to clearly elect the fee schedules such that Progressive would be required to reimburse the claim in accordance with the fact-dependent method set forth in the statute. Because of that determination and for other reasons, the county court determined that Count II was moot. This court has reviewed the almost 5,000-page record, the briefs, applicable Florida law, and heard oral argument. Having done so, the court determines that the policy provides clear notice of Progressive's intent to rely on the fee schedules in determining reasonable reimbursement. In addition, because the record plainly shows that Hess abandoned the MPPR issue, we remand the case only for the county court to enter judgment for Progressive.

Background:

The PIP statute, §627.736(1), requires insurers to pay up to $10,000 in reasonable medical expenses. The statute identifies two methods for calculating the reasonable reimbursement for those services. The first method, commonly referred to as the "fact-dependent" or "reasonableness" method, is found in §627.736(5)(a) and comprises several objective factors.[1] These factors include the usual and customary charges for like services in the community, the usual and customary charges and payments accepted by the provider involved in the dispute, and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages. §627.736(5)(a); *GEICO Gen. Ins. Co. v. Virtual Imaging Services*, 141 So. 3d 147, 155 (Fla. 2013) (*Virtual*). Historically, the fact-dependent method gave rise to significant litigation directed at determining the reasonable reimbursement for a set of services.

The legislature adopted the second method, hereinafter the "fee-schedule method," in 2008.[2] The fee-schedule method is based on a set of fixed amounts in accordance with Medicare fee schedules and other factors. Currently, the fee-schedule method is set forth in §627.736(5)(a)1-5.[3] The fee-schedule option provides a fixed fee for services that, if paid in accordance with its terms, is not subject to challenge. The 2008 amendment gave insurers the option to limit reimbursement for certain services rendered, such as MRIs, to "200 percent of the allowable amount under the participating physicians schedule of Medicare Part B." §627.736(5)(a)2.f. Although the 2008 statute did not then require it, subsequent case law developed the requirement that an insurer desiring to use the fee schedules must, in their written policies, provide notice of its intent to rely on the methodology in clear and unambiguous language. *Allstate Ins. Co. v. Orthopedic Specialists*, 212 So. 3d 973, 976-77 (Fla. 2017) (*Orthopedic Specialists*), *citing Virtual,* at 158-59. If this requirement were not met, payment determinations would revert to the fact-dependent method. *Virtual*, at 159-60. *See also State Farm Mut. Auto. Ins. Co. v. MRI Assoc. of Tampa, Inc. d/b/a Park Place MRI*, 252 So. 3d 773, 777 (Fla. 2d DCA 2018) (*Park Place*).[4]

The 2012 amendment renumbered the two methods so that the fact-dependent and fee-schedule methods appear in sections 627.736(5)(a) and (5)(a)1-5, respectively. Numbered this way the fee-schedule method appears as subordinate to the fact-dependent method. Because of this amendment, the recently decided *Park Place* determined that even when an insurer elects the fee-schedule method of claim reimbursement, it cannot disclaim the fact-dependent method. *Park Place,* at 778. Accordingly, the two methods are no longer mutually exclusive. *Id.* In addition, the 2012 amendment added a notice requirement the 2008 version did not contain.[5] It authorizes

[1] To avoid confusion, this court will refer to the method of determining claim reimbursement under §627.736(5)(a) as the "fact-dependent" method.

[2] This method is also known as the schedule of maximum charges.

[3] In 2008, the fact-dependent and fee-schedule methods were numbered §627.736(5)(a)1 and (5)(a)2, respectively. In 2012, the fact-dependent and fee-schedule methods were renumbered to §627.736(5)(a) and (5)(a)1, respectively.

[4] The court acknowledges that Supreme Court review has been sought in *Park Place.* When a district court of appeal issues an opinion deciding a point of law, however, that opinion is binding within that district and throughout the state where no other district court has issued a contrary opinion. *Link v. State,* --So. 3d--, 2019 WL 2017389 (Fla. 3d DCA May 8, 2019), *citing Pardo v. State*, 596 So. 2d 665, 666 (Fla. 1992).

[5] The notice requirement that does not appear in the statute between 2008 and 2012 was developed through case law starting with *Kingsway Amigo Ins. Co. v. Ocean Health, Inc.*, 63 So. 3d 63, 67-68 (Fla. 4th DCA 2011) culminating

insurers to use the fee-schedule method "only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph." §627.736(5)(a)5, Fla. Stat.

In the case below, the county court determined that the Progressive policy failed to clearly elect the fee-schedule method in its policy and entered summary judgment for Hess. Progressive appealed the judgment. In this appeal, this court reviews the county court's summary judgment under the de novo standard of review. *Volusia County v. Aberdeen of Ormond Beach, L.P.*, 760 So. 2d 126, 130 (Fla. 2000).

ISSUE 1. Whether Progressive's policy gave sufficient notice of its intent to use the fee-schedule method of PIP claim reimbursement under §627.736(5)(a)5.

The basic coverage mandate of the no-fault law that is referred to as the "fact-dependent" option defines "medical benefits" as "[e]ighty percent of all reasonable expenses for medically necessary medical, surgical, x-ray, dental, and rehabilitative services... ." §627.736(1)(a). *Orthopedic Specialists*, 212 So. 3d at 976 (quoting *Virtual*, 141 So. 3d at 155) (describing the provision as the "basic coverage mandate" in the PIP statutes). It allows a fact finder to consider several statutory factors to determine if a contested charge is reasonable.

Under the fee-schedule method, charges are reimbursed using "a schedule of maximum charges" (fee schedules) in §627.736(5)(a)1.(a.-f.). *Virtual*, at 154. The reasonableness of the medical charges under the fee schedules is determined by applying 80 percent of 200 percent of the applicable Medicare fee schedule. §627. 736(5)(a.)1.f. An insurer's ability to rely on the fee schedules to reimburse claims is not automatic. Section 627.736(5)(a)5 provides:

> Effective July 1, 2012, an insurer <u>may limit payment</u> as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. (Emphasis added.) A Policy Form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed subparagraph 1., the insurer may pay the amount of the charge submitted.

Virtual, at 154. The use of the fee schedules is permissive and requires notice before an insurance company may rely on them. *Id.*

The policy in this case provided the following PIP coverage:

> PART II (A)- PERSONAL INJURY PROTECTION COVERAGE INSURING AGREEMENT
> …we will pay benefits that an insured person is entitled to receive pursuant to the Florida Motor Vehicle No-Fault Law, as amended ...
> Personal Injury Protection Coverage benefits consist of:
> 1. medical benefits ....

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with *GEICO Gen. Ins. Co. v. Virtual Imaging Services*, 141 So. 3d 147, 158 (Fla. 2013) and *Allstate Ins. Co. v. Orthopedic Specialists*, 212 So. 3d 973, 977 (Fla. 2017). The 2012 amendment codifies a notice requirement.

ADDITIONAL DEFINITIONS
When used in this Part II (A):
4. "Medical benefits" means 80% of all reasonable expenses incurred for medically necessary medical, surgical, x-ray, dental and rehabilitative services…

The policy was renewed shortly before the accident in 2014. The A-85 policy endorsement form altered the above-referenced coverage as follows:

PERSONAL INJURY PROTECTION COVERAGE ENDORSEMENT

Effective January 1, 2013, the "Unreasonable or Unnecessary Medical Benefits" provision in Part II(A), and in any endorsements to Part II(A), is deleted and replaced by the following:

UNREASONABLE OR UNNECESSARY MEDICAL BENEFITS
If an insured person incurs medical benefits that we deem to be unreasonable or unnecessary, we may refuse to pay for those medical benefits and contest them. We will determine to be unreasonable any charges incurred that exceed the maximum charges set forth in Section 627.736 (5)(a)(1) (a through f) of the Florida Motor Vehicle No-Fault Law, as amended. Pursuant to Florida law, we will limit reimbursement to, and pay no more than, 80 percent of the following schedule of maximum charges:

[Tracks the language in §627.736(5)(a)(1) a. – f.]

The applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which the services, supplies or care is rendered and for the area in which such services, supplies or care is rendered. This applicable fee schedule or payment limitation applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedules of Medicare Part B for 2007 for medical services, supplies and care subject to Medicare Part B. In determining the appropriate reimbursement under the applicable Medicare fee schedule, all reasonable, medically necessary, and covered charges for services, supplies and care submitted by physicians, non-physician practitioners, or any other provider will be subject to the Center for Medicare Services (CMS) coding policies and payment methodologies, including applicable modifiers. The CMS policies include, but are not limited to: coding edits, both mutually exclusive and inclusive, payment limitations, and coding guidelines subject to the National Correct Coding Initiative (NCCI), Hospital Outpatient Prospective Payment System (OPPS), Multiple Procedure Payment Reduction (MPPR), and Multiple Surgery Reduction Rules (MSRR).

We will reduce any payment to a medical provider under this Part II(A) by any amounts we deem to be unreasonable medical benefits. However, the medical benefits shall provide reimbursement only for such services, supplies and care that

are lawfully rendered, supervised, ordered or prescribed. Any reductions taken will not affect the rights of an insured person for coverage under this Part II(A). Whenever a medical provider agrees to a reduction of medical benefits charged, any co-payment owed by an insured person will also be reduced.

(Emphasis ours.)

Comparatively, §627.736(5)'s relevant language reads as follows:

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
(a) A physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. However, such a charge may not exceed the amount the person or institution customarily charges for like services or supplies. In determining whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.[6]

1. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:[7]

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002 provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

[6] The foregoing language constitutes the fact-dependent method for calculating PIP reimbursement benefits.

[7] The fee-schedule method follows.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under:

(I) The participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2. For purposes of subparagraph 1., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the service year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies to services, supplies, or care rendered during that service year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B. For purposes of this subparagraph, the term "service year" means the period from March 1 through the end of February of the following year.

3. Subparagraph 1. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph

> 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

The summary judgment order we review here determined that Progressive's policy endorsement contained "several significant deviations" from the statute. First, it said the policy did not unambiguously invoke the schedule where the policy provided that Progressive reserved the right to deem charges exceeding the fee schedules as "unreasonable." Hess contends this use conflates the two methods, thus creating a hybrid method. Second, the order says there is no evidence that the Office of Insurance Regulation (OIR) approved the policy endorsement. Third, the order says, and Hess maintains, that the policy omitted certain statutory language that created an ambiguity.[8] Finally, Hess contends Progressive's stated intent to rely specifically on "Center for Medicare Services (CMS)" coding policies is ambiguous because, among other things, it relies on coding policies not specifically enumerated in the statute.

The policy language clearly elects the fee schedules and does not create a hybrid methodology of calculating PIP reimbursements. The policy endorsement incorporates the very text of the schedule of maximum charges in subsection 627.736(5)(a)1. (a-f). Indeed, much less detailed language has been determined to be sufficient notice. *See, e.g., Park Place,* 252 So. 3d at 778; *Florida Wellness & Rehab. v. Allstate Fire & Cas. Ins. Co.,* 201 So. 3d 169, 171-72 (Fla. 3d DCA 2016); *Orthopedic Specialists,* 212 So. 3d at 979 (Fla. 2017); *Virga v. Progressive Am. Ins. Co.,* 215 F. Supp. 3d 1320, 1324-25 (S.D. Fla. 2016) (policy referring to insurer's statutory obligation to pay 80 percent of all reasonable expenses for medically necessary services and detailing the manner in which insurer determines what qualifies as reasonable under §627.736(1)(a) is a valid election of the fee schedules).[9]

The fact that the policy defines charges that exceed the fee schedules as "unreasonable" does not render the policy ambiguous. The use of the word "reasonable" or "unreasonable" in the generic sense does not create an ambiguity. The fee schedules are simply another way of determining reasonable reimbursement. The policy language also does not create a so-called "hybrid" method. In *Park Place*, State Farm's policy similarly limited payments to the fee schedules, stating "in no event will we pay more than 80 percent of the following No-fault Act

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[8] The following language appears in the statute, but not in the policy:

> 3. Subparagraph 1. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

[9] This court realizes *Virga* is not binding; however, we find it persuasive.

schedule of maximum charges, including Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services…" The State Farm policy defined "reasonable charge" to include "usual and customary charges," "payments accepted by provider," "reimbursement levels in the community," "various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages," *and* "the schedule of maximum charges in the No-fault Act." *Park Place*, 252 So. 3d at 775. Notably, the first four items are factors in the fact-dependent methodology, while only the last item is the fee-schedule methodology. *Id.* Thus, in contrast to the Progressive policy here, both methods were referred to in State Farm's policy.

We now turn our attention to Hess's assertion that the record lacks evidence that the OIR approved the policy's adoption of the fee schedule as further evidence of its ambiguity. Progressive disputes this assertion, having submitted an affidavit of a company representative who represented that the policy received OIR approval. It is unnecessary to address the evidentiary question here. Although the statute indicates that a particular form approved by the OIR would suffice to elect the fee-schedule methodology, it does not say that OIR approval is mandatory for an election to be valid. *See* §627.736(5)(a)5. Indeed, the summary judgment order itself disclaims the effect of OIR approval on technical grounds.[10] In effect, the order says, and this court agrees, that OIR approval does not automatically validate the sufficiency or enforceability of the contents of the policy. Conversely, the absence of OIR approval does not necessarily invalidate the endorsement here.

We are also unpersuaded that the policy is ambiguous because it *omitted* the statutory provision in 627.7365(a)3, *i.e.*, that the fee schedule method "does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or worker's compensation." There is no requirement that the insurer incorporate the statute verbatim to elect the fee schedule. The omission of that language does not entitle an insurer to disregard the law, and there has been no showing that Progressive did so.

Finally, we address Hess's assertion that the policy's intent to rely on CMS coding policies such as MPPR means that Progressive will pay even less than the fee schedule and that this renders the policy ambiguous. An amount rendered in accordance with the fee schedule, using any coding policy and payment methodology permitted by CMS and the statute, as long as it is not a utilization limit, simply cannot be less than the amount allowed by the fee schedule. And the statute clearly allows insurers to use CMS coding policies *if* they do not constitute a utilization limit. *See* §627.736(5)(a)3 (subparagraph 1 does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services…to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit). The reference to enumerated CMS coding policies does not invalidate the policy in the absence of any evidence that Progressive's reliance on any coding policy violated the statute's prohibition on utilization limits. There was no such evidence.

[10] Paragraph 51 of the summary judgment order says "the OIR memorandum contains disclaimers one of which states: 'Ultimately, it is the insurer's responsibility to develop its own language after researching the issue, reviewing its contract forms, and conferring with its legal staff.'"

For the foregoing reasons, the trial court erred in entering judgment for Hess on Count I of the complaint, and the judgment below must be set aside. The policy of insurance clearly elected the fee-schedule method of PIP claim reimbursement.

ISSUE 2. Whether the county court should be directed to enter judgment for Progressive on remand or whether it should consider the issues in Count II of the complaint.

We now turn our attention to whether this court should mandate the county court to enter judgment for Progressive or remand this cause for further proceedings on the second count of the complaint. Count II sought relief related to Progressive's use of MPPR, which Hess claims is a statutorily prohibited utilization limit. Although it was improperly argued in tandem with the first count below, the county court deemed Count II moot because Hess elected its remedy under Count I. The election of remedies doctrine operates on the theory that a party electing one course of action cannot avail himself of an incompatible course. It exists only where the remedies in question are coexistent and inconsistent. *See, e.g., Plumbing Service Co. v. Progressive Plumbing, Inc.*, 46 So. 3d 144, 145-46 (Fla. 5th DCA 2010). It does not apply where, as here, the law provides several distinct, but not inconsistent, remedies for the enforcement of a right. *Id.* (*Internal citations omitted*.) In this case, Count II is not an inconsistent remedy.[11] To the extent there is error, the error was invited. The record shows clearly that Hess intentionally abandoned the issue. The transcript of the summary judgment hearing contains no fewer than four statements by Hess that Count II was rendered moot by the court's decision on Count I. To the extent it was not sufficiently clear, counsel for Hess also indicated his client's intent to abandon the issue, adding that it had elected its remedy.[12] Under the circumstances, the issue cannot be revived for further consideration on remand. *Sheffield v. Superior Ins. Co.*, 800 So. 2d 197, 202-03 (Fla. 2001) (the "invited-error doctrine" prohibits a party from making or inviting error at trial and then taking advantage of the error on appeal).

It is therefore ORDERED that the judgment below is REVERSED, and the cause is REMANDED to the county court. On remand, the court is directed to enter judgment for Progressive. It is FURTHER ORDERED that Appellee's motion for appellate attorney's fees is DENIED.

ORDERED on the date imprinted with the Judge's signature.

By: Electronically Conformed 8/27/2019
Cheryl Thomas
CHERYL A. THOMAS, Circuit Judge

THOMAS, COOK, HUEY, JJ.

Electronic copies provided to all associated parties by JAWS

[11] Whether the insurer clearly adopted the fee-schedule method is independent of the question whether MPPR is a coding policy available to insurers.

[12] R. 4822-24