NOT FINAL UNTIL DISPOSAL OF TIMELY-FILED MOTION FOR REHEARING OR CLARIFICATION

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

COUNTYLINE CHIROPRACTIC MEDICAL & REHAB CENTER a/a/o Sonia Ambrose,
Appellant,

APPELLATE DIVISION

CASE NO.: 2017-378-AP-01

v.

LOWER TRIBUNAL CASE NO.: 2015-19152SP23 (06)

PROGRESSIVE SELECT INSURANCE COMPANY,
Appellee.
_____/

Opinion filed: May 6, 2020.

An Appeal from the County Court for Miami-Dade County, Spencer Multack, Judge.

Myones Legal PLLC, Howard W. Myones, Esq. and Marlene S. Reiss, Esq., P.A., for Appellant

KUBICKI DRAPER, P.A., Andrew T. Lynn and Michael C. Clarke, for Appellee.

Before TRAWICK, WALSH, and BOKOR, JJ.

WALSH, J.

Sonia Ambrose was injured in a car accident and treated by Appellant Countyline Chiropractic Medical & Rehab Center ("Countyline" or

"Provider"). Ms. Ambrose assigned her personal injury protection (PIP) benefits with Appellee, Progressive Select Insurance Company ("Progressive Select" or "Insurer"), to her provider. The trial court granted summary judgment in favor of Progressive Select.

Countyline raises three issues on appeal. First, Countyline argues that the PIP policy improperly elected reimbursement at 200% of the Medicare Part B fee schedule. Second, Countyline argues that the Insurer improperly applied the MPPR deductions which were unlawful "utilization limits." Third, Countyline argues that the Insurer improperly reduced the bills before applying the deductible.[1]

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[1] Since we must reverse the summary judgment order because the Insurer improperly applied the deductible, the Appellant Countyline argues that we should not address the remaining issues because they are moot, citing *J.B. v. State*, 29 So. 3d 300 (Fla. 2d DCA 2010), and a number of other decisions.

Mootness affects an appellate court's very jurisdiction. It means that there is no purpose to the litigation because the issues have been resolved, rendering any resulting opinion advisory in nature. *Merkle v. Guardianship of Jacoby*, 912 So. 2d 595, 599 (Fla. 2d DCA 2005) ("The doctrine of mootness is a corollary to the limitation on the exercise of judicial power to the decision of justiciable controversies. Generally speaking, an appellate court will dismiss a case if the issues raised in it have become moot."). Our jurisdiction is not divested because one issue of the several raised must result in a reversal.

Moreover, the remaining issues raised in this appeal are likely to recur on remand, even after the damages are recalibrated under a proper application of the deductible. Once the trial judge assesses the damages, the Provider or Insurer could well argue anew whether the fee schedule or MPPR reductions may be applied. Further, in addressing these issues now, the Provider may, if it wishes, seek further review in the pipeline following

The standard of review of a trial court's entry of final summary judgment is de novo. *See Volusia Cnty. v. Aberdeen at Ormond Beach, L.P.*, 760 So. 2d 126, 130 (Fla. 2000); *Sierra v. Shevin*, 767 So. 2d 524, 525 (Fla. 3d DCA 2000). Summary judgment is proper when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *State Farm Mut. Auto. Ins. Co. v. Gonzalez*, 178 So. 3d 448, 450 (Fla. 3d DCA 2015), *citing State Farm Mut. Auto. Ins. Co. v. Pressley*, 28 So. 3d 105, 107 (Fla. 1st DCA 2010). The three issues on appeal address pure questions of law.

1. Insurer's Policy Language was Sufficient Under Section 627.736(5)(a)5 to Reimburse Under Section 627.736(5)(a)1.f., Florida Statutes (2013)

Turning to the first issue on appeal, the Provider argues that the Insurer improperly failed to make a clear and unambiguous election in its policy of its right to reimburse for medical services using 200% of the Medicare Part B Fee Schedules. The Provider argues that the Progressive Select policy in effect here violated the notice requirements set forth in *Geico Gen. Ins. Co. v. Virtual*

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the Supreme Court of Florida's review of *State Farm Mut. Auto. Ins. Co. v. MRI Assocs. of Tampa, Inc*., 252 So. 3d 773 (Fla. 2d DCA 2018), *review granted*, No. SC18-1390, 2019 WL 3214553 (Fla. July 17, 2019). Therefore, in order to avoid piecemeal litigation and to give clearer guidance to the trial court on remand, we find that the remaining issues on appeal are not moot and should be decided in this appeal.

Imaging Services, Inc., 141 So. 3d 147 (Fla. 2013) and *Allstate Ins. Co. v. Orthopedic Specialists, Inc.*, 212 So. 3d 973, 977 (Fla. 2017).

Progressive Select's policy notified the insured as follows:

> 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 not more than, 80 percent of the following schedule of maximum charges:
>
> * * *
>
> f. for all other medical services, supplies, and care, 200 percent of the allowable amount under the participating physicians fee schedule of Medicare Part B . . . .

We must determine whether this policy election is permissible under the applicable PIP statute.

In *Virtual Imaging*, the court analyzed whether an insurer could -- unilaterally, and without notice to its insured -- elect to reimburse its insured at 200% of Medicare Part B. *Virtual Imaging*, 141 So. 3d at 152. The 2008 version of the PIP statute then in effect, Section 627.736(5)(a)(2), Florida Statutes, provided that, "insurers 'may limit reimbursement' to eighty percent of a schedule of maximum charges set forth in the PIP statute." *Id.* at 154. In order to avail itself of this option, however, the court in *Virtual Imaging* held

that an insurer may not unilaterally elect this reimbursement method but instead, must in its policy "clearly and unambiguously elect the permissive payment methodology in order to rely on it." *Id.* at 158. However, the court restricted its holding to policies written under the 2008 version of the No Fault statute, which had not yet been amended. *Id.* at 150.

Later, in *Allstate Ins. Co. v. Orthopedic Specialists, Inc.*, 212 So. 3d 973, 977 (Fla. 2017), the court approved an Allstate policy written under the 2009 PIP statute which clearly and unambiguously elected reimbursement under Section 627.736(5)(a)2, or at 200% of the Medicare Fee schedule. *Id.* at 976. The court analyzed the 2009 statute in its decision in *Orthopedic Specialists*; the 2009 statute, like the 2008 statute, had not yet been amended.

The policy in this case was written in 2014. In 2012, the legislature made substantive changes to the No Fault statute. The legislature enacted Section 627.736(5)(a)5., Florida Statutes, which provides:

> 5. Effective July 1, 2012, an insurer may limit payment 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. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

Ch. 2012-197, § 10, at 22, Laws of Fla. The policy language in the Progressive Select policy complies with this statutory provision. Therefore, contrary to the

Provider's argument, Progressive Select was required merely to give simple notice that it "may" limit reimbursement applying the fee schedule, rather than a "clear and unambiguous" election required by *Virtual Imaging* and *Orthopedic Specialists*. These opinions analyzed the 2008 and 2009 No Fault statutes, respectively, and do not apply to policies written after 2012.

Moreover, in amending section 627.736(5), the legislature renumbered all reimbursement methods under a single subsection – 627.736(5)(a) – which specifically requires that an insured or provider "may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, ..." Further limitations of reimbursement are contained within section 627.736(5)(a)1., which evinces the intent that the Medicare Fee Schedule and other reimbursement methods are subsets of the general requirement that reimbursement be "only a reasonable amount."

Thus, instead of two discrete reimbursement methods – a reasonable amount **or** fee schedule (or other) limited reimbursement method, now there is one – a reasonable amount, within which, the insurer "may" elect to reimburse according to certain fee schedules. And the notice of that intent need only be general – that the insurer may elect to reimburse under a fee schedule or other limited reimbursement.

Secondly, the court in *State Farm Mut. Auto. Ins. Co. v. MRI Assocs. of*

Tampa, Inc., 252 So. 3d 773 (Fla. 2d DCA 2018), *review granted*, No. SC18-1390, 2019 WL 3214553 (Fla. July 17, 2019), concluded that after the statutory amendments, insurers need only give a simple notice of intent to reimburse using fee schedules and further explained:

> In 2012 the legislature substantially amended section 627.736(5), setting forth the schedule of maximum charges limitation as a subsection of the reasonable charge calculation methodology. Ch. 2012–197, § 10, at 2743–44, Laws of Fla. As a result of this amendment, the reasonable charge and schedule of maximum charges methodologies are no longer coequal subsections of 627.736(5)(a); **instead the reasonable charge method is set forth in subsection (5)(a), and the schedule of maximum charges limitation is provided in subsection (5)(a)(1). Based on the current construction of the PIP statute, we conclude that there are no longer two mutually exclusive methodologies for calculating the reimbursement payment owed by the insurer**.

Id. at 777-78 (emphasis added).

The *MRI Associates* decision is currently pending review in the Supreme Court of Florida. However, in the absence of a conflicting opinion from another District Court of Appeal, we are bound by the Second District Court of Appeal's decision in *MRI Associates*. *See Pardo v. State*, 596 So. 2d 665 (Fla. 1992). We therefore affirm the trial court's ruling that the policy at issue complied with the statutory notice requirements for reimbursement under a fee schedule.

2. **The Application of the Multiple Procedure Payment Reduction (MPPR) is not an Unlawful Limitation of Treatment or Other Utilization Limit**

The Provider next argues that Progressive Select improperly reduced its reimbursement by applying the Multiple Procedure Payment Reduction (MPPR) to services performed on the insured on the same date of service. Progressive Select's policy states:

> In determining the appropriate reimbursement under the applicable Medicare fee schedules, all reasonable, medically necessary, and covered charges 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: . . . Multiple Procedure Payment Reduction (MPPR),** . . . .

Progressive Select further reduced the reimbursement for medical costs using the MPPR reduction. The Provider argues that such a reduction is an improper limitation on the number of treatments or other "utilization limit" in violation of Section 627.736(5)(a)3., Florida Statutes (2013).

Congress passed the American Taxpayer Relief Act of 2012. Section 633 of the Act, "Treatment of multiple service payment policies for therapy services," allows for payment reductions for multiple services performed on the same date. *See* 42 U.S.C.A. § 1395m(k)(7) (West); American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 633, 126 Stat 2313 (2013). Section (k) of this provision addresses "Payment for outpatient therapy services and

comprehensive outpatient rehabilitation services." Included within the section are efficiencies and fee limitations, including fee schedules, adjusted reasonable costs, restraint on billing, savings, in short, all subjects addressed toward reducing the cost of medical services. The statutory language of 42 U.S.C.A. § 1395m(k)(7) is clear and unambiguous. But even if it were not, considering its meaning *in pari materia* with the other provisions in section (k) of the statute reflects Congress' clear intent to govern reduction of costs for medical services, not reduction of medical services. *See E.A.R. v. State*, 4 So. 3d 614, 628 (Fla. 2009) ("'The doctrine of *in pari materia* is a principle of statutory construction that requires that statutes relating to the same subject or object be construed together to harmonize the statutes and to give effect to the Legislature's intent.'") (quoting *Fla. Dep't of State v. Martin*, 916 So. 2d 763, 768 (Fla. 2005)).

The Congressional Research Service published *Medicare, Medicaid, and Other Health Provisions in the American Taxpayer Relief Act of 2012*, in which it described the MPPR as follows:

> Following recommendations from GAO and MedPAC, CMS has established and implemented multiple procedure payment reduction (MPPR) policies to adjust payment to more appropriately reflect efficiencies gained when certain services are provided together, for example, when multiple similar services are performed on the same patient during the same visit. These payment reductions reflect efficiencies that typically occur in either the practice expense (PE) or professional work

component or both when services are furnished together.

Medicare, Medicaid, and Other Health Provisions in the American Taxpayer Relief Act of 2012, 2013 WL 1401568, at *11. With respect to allowing PIP insurers to use Medicare coding policies and payment methods, Florida amended Section 627.736(5)(a)(4), Florida Statutes, to be renumbered as 627.736(5)(a)3., and made the following substantive changes:

> 3.~~4.~~ Subparagraph 1. ~~2.~~ 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. ~~2.~~ must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is ~~would be~~ 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.

Ch. 2012-197, § 10, at 22, Laws of Fla. (additions indicated by underline; deletions indicated by ~~strikethrough~~).

The language and purpose of 42 U.S.C.A. § 1395m(k)(7) supports the conclusion that the MPPR is not a limitation on services nor another utilization limit, but rather, is a coding policy and payment methodology. Such a

payment methodology is expressly permitted by Section 627.736(5)(a)3., Florida Statutes.

Further, in determining the meaning of a statute, we look to the language used by the legislature. *Geico Gen. Ins. Co. v. Beacon Healthcare Ctr. Inc*., No. 3D18-2030, 2020 WL 912938, 45 Fla. L. Weekly D437 (Fla. 3d DCA Feb. 26, 2020). Section 627.736(5)(a)3. forbids limiting the number of treatments "or other utilization limits." The word 'utilization' means "to make use of: turn to practical use or account." *Utilize*, Merriam-Webster Online (2020).[2] In short, utilization means use. The patient is the user of services, not the provider. Therefore, in determining whether the MPPR is a utilization limit, the focus should be on the number and extent of services used by the patient, not the amount of reimbursement to the provider. The No Fault statute caps reimbursement at a total amount of $10,000. § 627.739(2), Fla. Stat. (2013). Reduction of the cost of each service does not reduce the number of services the patient may receive – it enables the patient to receive more. Thus, the practical effect of applying the MPPR supports the conclusion that it is not a utilization limit.

Every decision from this court which has analyzed whether the MPPR constitutes any kind of "utilization limit" has concluded that MPPR is a

[2] https://www.merriam-webster.com/dictionary/utilize.

limitation on cost, not on services. *See South Florida Institute of Wellness and Rehab, LLC a/a/o Jennifer Trinidad v. Progressive Select Ins. Co.*, 27 Fla. L. Weekly Supp. 433b (Fla. 11th Cir. Ct. July 12, 2019); *State Farm Mutual Auto. Ins, Co. v. Pan Am Diagnostic Servs. Inc., a/a/o Cristina Lasaga*, 27 Fla. L. Weekly Supp. 19a (Fla. 11th Cir. Ct. Mar. 1, 2019); *State Farm Mutual Auto. Ins. Co. v. Millennium Radiology, LLC d/b/a Mobile Imaging of America a/a/o Jorge Sanchez*, 26 Fla. L. Weekly Supp. 871a (Fla. 11th Cir. Ct. Jan. 9, 2019); *State Farm Mutual Auto. Ins. Co. v. Pan Am Diagnostic Servs. d/b/a Wide Open MRI a/a/o Maxime Jean Louis*, 26 Fla. L. Weekly Supp. 466b (Fla. 11th Cir. Ct. Sept. 5, 2018).

We accordingly affirm the trial court's order determining that the MPPR is not an impermissible limitation of services nor other utilization limit.

3. The Insurer Improperly Reduced the Bills by the Fee Schedule Before Applying the Deductible

Finally, the Provider correctly argues that the Insurer improperly applied the deductible *after* reducing the bills by the Medicare fee schedule. In *Progressive Select Ins. Co. v. Fla. Hosp. Med. Ctr*., 260 So. 3d 219, 220 (Fla. 2018),[3] the court concluded, the amendment to "section 627.739(2) to require that "[t]he deductible amount ... be applied to 100 percent of the expenses and

[3] At the time the trial court entered the order granting summary judgment, it did not have the benefit of the decision in *Progressive Select Ins. Co.*.

losses described in s. 627.736" meant that the deductible must be applied to the total amount of the bills *before* any further reductions were made. *Id.* at 225.

We therefore reverse the order granting summary judgment on the application of the deductible, and remand for the trial court to determine the damages due to the Provider by applying the deductible to 100% of the charges before applying any reductions.

TRAWICK and BOKOR, JJ., concur.

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