IN THE CIRCUIT COURT OF THE NINTH JUDICIAL CIRCUIT,
IN AND FOR ORANGE COUNTY, FLORIDA

MEDICAL HEALTH CHOICE, P.A.,
a/a/o FRANK BEZERRA

APPELLATE CASE NO: 2017-CV-000085-A-O
LOWER COURT CASE NO: 2015-SC-004506-O

Appellant,
vs.

PROGRESSIVE AMERICAN
INSURANCE COMPANY,

Appellee.
_____/

Appeal from the County Court,
for Orange County, Florida,
Eric H. DuBois, County Judge.

Chad A. Barr, Esq.
Law Office of Chad A. Barr, P.A.
Attorney for Appellant

Douglas H. Stein, Esq.
Association Law Group, P.L.
Attorney for Appellee

Before ADAMS, JORDAN, MARQUES, JJ.

PER CURIAM.

Medical Health Choice, P.A. ("Appellant"), as assignee of Frank Bezerra, brought an action to recover Personal Injury Protection ("PIP") benefits for treatment rendered to Frank Bezerra, an insured of Progressive American Insurance Company ("Appellee"). Appellant filed a timely appeal of the trial court's Order granting the Appellee's/Defendant's Motion for Summary Final Judgment. We have jurisdiction. *See* § 26.012(1), Fla. Stat. (2018); Fla. R. App. P. 9.030(c)(1)(A). We dispense with oral argument. Fla. R. App. P. 9.320. We affirm.

BACKGROUND

The undisputed facts are as follows: on April 16, 2015, the Appellant filed a PIP suit, as assignee of Frank Bezerra, against the Appellee for reduced and/or denied medical bills for services rendered to Frank Bezerra, as a result of injuries sustained in an automobile accident which occurred on November 13, 2014. Frank Bezerra was insured under a PIP policy of insurance issued by the Appellee. Said policy was in full force and effect on the date of loss, and it had a $10,000 limit with a $1,000 deductible. The policy provided PIP benefits in accordance with the requirement of section 627.736, Florida Statutes. Frank Bezerra received treatment from the Appellant and assigned his benefits under his PIP policy with the Appellee to the Appellant. Only two medical providers submitted bills to the Appellee during the course of Frank Bezerra's PIP claim – Appellant and Precision Diagnostics, Inc. Appellee ultimately issued $10,000 in total PIP payments divided between the two providers as follows: $8,342.16 to the Appellant and $1,657.16 to Precision Diagnostics, Inc.

The Appellant timely submitted medical bills to the Appellee for services rendered to Frank Bezerra from November 14, 2014, through February 2, 2015. The Appellee received two pre-suit demand letters from the Appellant which complied with section 627.736(10), Florida Statutes. On March 4, 2015, the Appellant submitted its first Pre-suit Demand Letter to Appellee seeking PIP payments for treatment rendered to Frank Bezerra for the dates of service November 14, 2014, through December 10, 2014. On March 27, 2015, the Appellee timely responded to the Appellant's first Pre-suit Demand Letter and issued an additional payment for said dates of service. The Appellee applied the $1,000 deductible to the bills received on December 18, 2014, for dates of service November 14, 2014, through December 10, 2014. The amount billed by the Appellant for these dates of service was $5,270.00. The Appellee reduced the total amount billed by the

Appellant pursuant to 200% of the Medicare Part B fee schedule and then applied the $1,000 deductible to the reduced amount instead of the full amount billed of $5,270.00.

On April 10, 2015, the Appellant submitted a second Pre-suit Demand Letter to the Appellee seeking benefits under the same policy, but for dates of service December 12, 2014, through February 2, 2015. On April 16, 2015, the Appellant filed the action against the Appellee seeking PIP benefits for dates of service rendered only in the first Pre-suit Demand Letter, November 14, 2014, through December 10, 2014.[1] On May 13, 2015, the Appellee timely responded to the Appellant's second Pre-suit Demand Letter and issued payment for $2,623.70, which resulted in the Appellee reaching the policy limits of $10,000 in PIP benefits. There is no dispute that the Appellant received this $2,623.70 draft but chose not to deposit it.

The Appellee filed its Answer and Affirmative Defenses in response to the Amended Complaint denying all relevant allegations and raising the Affirmative Defense that benefits exhausted on May 13, 2015, when a payment was made to the Appellant that exhausted the full extent of available insurance benefits under the insurance policy. The Appellant filed its Denial/Reply to Defendant's Answer and Affirmative Defenses raising the following arguments: Appellee breached the policy before benefits exhausted, benefits did not exhaust because the check sent to the Appellant had not been cashed, and the Appellee acted in bad faith.

On September 4, 2015, the Appellee filed its Motion for Summary Final Judgment and Motion for Protective Order Based on Exhaustion of Benefits. The Appellee argued that it was not responsible to pay any additional PIP benefits because from January 28, 2015, through May 13, 2015, it paid the coverage limits of $10,000 to Frank Bezerra's medical providers, including the Appellant, thereby exhausting all benefits available under the policy. The Motion was supported

[1] On May 22, 2017, the Appellant filed its Amended Complaint to add in the additional dates of service listed in its April 15, 2015, pre-suit demand letter – November 14, 2014, through February 2, 2015.

with an Affidavit from its Litigation Specialist. The Appellant filed its Response to the Motion for Summary Final Judgment asserting three main arguments: 1) the Appellee improperly applied the deductible by applying it to the reduced fee schedule amount of reimbursement rather than to the amount that the Appellant charged; 2) the Appellee paid the medical bills out of order in violation of the English Rule of Priorities ("English Rule") and therefore acted in bad faith; and 3) benefits had not actually exhausted because the Appellant did not cash the check issued on May 13, 2015, as payment for its bills. The Response was supported by an Affidavit of its Billing Custodian's Corporate Representative and the deposition transcript of the Appellee's Senior PIP Litigation Representative.

On January 22, 2017, the trial court held a hearing on the Appellee's Motion for Summary Final Judgment and on June 30, 2017, entered its Order Granting Final Summary Judgment. As to the argument that benefits were not exhausted because the Appellant did not cash the check issued on May 13, 2015, the trial court found that section 627.736(10(d), Florida Statutes, provides that "payment" is deemed made when the check is placed in the mail, not when the funds are deposited into the recipients' bank account. Regarding the argument that the Appellee violated the English Rule, the trial court ruled that the English Rule does not apply to PIP benefits that are in dispute. Regarding the argument that the Appellee misapplied the deductible, the trial court ruled that the issue was irrelevant because the Appellant was unable to show any additional benefits owed regardless of how the deductible was applied. In other words, the Appellant provided no record evidence that it should or would have received more than the $8,342.16 in PIP benefits it ultimately received. Thus, the Appellant had no damages. As to the argument that the Appellee acted in bad faith, the trial court ruled that the Appellant did not file a civil remedy notice, a condition precedent to filing a bad faith claim. In sum, the trial court held that the benefits had exhausted, and the

Appellee could not be liable for any insurance benefits in excess of the $10,000 limits provided by the policy. Judgment was entered in favor of the Appellee, and this timely appeal followed.

STANDARD OF REVIEW

This Court reviews orders on motions for summary judgment *de novo*. *Volusia Cty. v. Aberdeen at Ormond Beach, L.P.*, 760 So. 2d 126, 130 (Fla. 2000). Summary judgment must be granted where the summary judgment evidence shows the absence of any "genuine issue as to any material fact" and an entitlement to judgment as a matter of law. Fla. R. Civ. P. 1.510(c). The moving party has the burden of establishing the absence of any genuine issue of material fact, and all reasonable inferences are drawn in favor of the non-moving party. *J.P. Morgan Sec., LLC v. Geveran Invs. Ltd.*, 224 So. 3d 316, 323 (Fla. 5th DCA 2017).

DISCUSSION

I. Whether a PIP insurer can be liable for PIP benefits after the full extent of the available PIP coverage has been paid.

The main issue on appeal is whether or not the Appellee, a PIP insurer, can be held liable for PIP benefits above the statutory limit after the benefits provided for in the insurance policy have been exhausted. Specifically, the Appellant argues that the Appellee was not entitled to a final summary judgment on its exhaustion of benefits defense because the Appellant pled and presented sufficient evidence that: 1) the Appellee engaged in improper and/or bad faith claims handling and bad faith is an exception to the exhaustion of benefits defense; 2) the Appellee violated the English Rule of Priorities because the underpaid claims were compensable and overdue before the benefits were exhausted; and 3) that some of the Appellee's payments were gratuitous and should not count

towards determining whether benefits exhausted.[2] We will address each argument in turn and for the reasons set forth below, we affirm the trial court.

Because PIP coverage is a creature of statute, any evaluation of that coverage must be made in accordance with the purpose of that statute. The primary purpose of PIP benefits is to provide up to $10,000 for medical bills and lost wages without regard to fault and to provide swift and virtually automatic payment so that the injured insured may get on with his or her life without undue financial interruption. *Flores v. Allstate Ins. Co.*, 819 So. 2d 740, 744 (Fla. 2002); *Geico Indem. Co. v. Gables Ins. Recovery, Inc.*, 159 So. 3d 151, 154 (Fla. 3d DCA 2014). Every insurance policy issued in compliance with section 627.733, Florida Statutes (2015), "shall provide personal injury protection to the named insured . . . to a limit of $10,000 for loss sustained . . . as a result of bodily injury . . . arising out of the . . . use of a motor vehicle." § 627.736(1), Fla. Stat. (2015). On its face, nothing in the PIP statute requires an insurer to pay in excess of the $10,000 limit in PIP coverage.

Accordingly, Florida courts have established that, once an insurer has paid out the policy limits to the insured (or to various providers as assignees), it is not liable to pay any further PIP benefits, even those in dispute. *Richard A. Sheldon, D.C. v. United Servs. Auto. Ass'n*, 55 So. 3d 593, 595 (Fla. 1st DCA 2010); s*ee also Progressive American Ins. Co. v. Stand-Up MRI of Orlando*, 990 So. 2d 3 (Fla. 5th DCA 2008); *Millennium Diagnostic Imaging Center, Inc. v. Progressive Express Ins. Co.*, 987 So. 2d 755 (Fla. 3d DCA 2008); *Simon v. Progressive Express Ins. Co.*, 904 So. 2d 449 (Fla. 4th DCA 2005). As such, a claim for unpaid benefits becomes obviated by the exhaustion of benefits, and the issue of whether the claim was improperly denied becomes superfluous. *Sheldon*, 55 So. 3d at 59.

[2] The Appellant has abandoned its argument that the benefits did not exhaust because it refused to cash the May 13, 2015 check. As such, the Court will not address the argument.

However, in both *Simon* and *Stand–Up MRI* the Fourth and Fifth District Courts of Appeal respectively held that a showing of bad faith or impropriety on the part of the insurer in reducing or denying benefits is required before an insurer can be held liable for benefits above the statutory limit. Specifically, in *Stand–Up MRI*, the Fifth District held that "in the absence of a showing of bad faith, a PIP insurer is not liable for benefits once benefits have been exhausted." *Id.* at 4; s*ee also Geico Indem Co.*, 159 So. 3d at 155 (holding that a showing of bad faith is required before the insurer can be held liable for benefits above the statutory limit). Moreover, the Fourth District Court of Appeal extended the reasoning of *Simon* and *Stand–Up MRI* and stated the following:

> We hold that post-suit exhaustion of benefits should be treated no differently than pre-suit exhaustion of benefits, as long as the benefits' compensability under PIP has not been established. Once the PIP benefits are exhausted through the payment of valid claims, an insurer has no further liability on unresolved, pending claims, absent bad faith in the handling of the claim by the insurance company.

Northwoods Sports Med. & Physical Rehab., Inc. v. State Farm Mut. Auto. Ins. Co., 137 So. 3d 1049, 1057 (Fla. 4th DCA 2014). The underlying principle is that the insurance company has the obligation to attempt to settle as many claims as possible. *Simon*, 904 So. 2d at 450 (citation omitted). It is also the prerogative of insurance companies to pay, reduce, or deny claims. *Id*. (citation omitted).

a. <u>Whether an insurer's alleged bad faith is an exception to the exhaustion of benefits defense, thereby creating a genuine issue of material fact as to whether Appellee engaged in improper and/or bad faith claims handling.</u>

The Appellant contends that the trial court erred in granting final summary judgment in favor of the Appellee because an insurer may be liable for benefits in excess of the policy limits when the insurer exhausts the benefits in bad faith, and the Appellant asserts that the Appellee exhausted Frank Bezerra's benefits in bad faith. Specifically, the Appellant argues that evidence was presented to the trial court that the Appellee engaged in improper and/or bad faith claims

handling when it unlawfully reduced and denied payment of the claims without obtaining reasonable proof that it was not responsible for payment as required by section 627.736(4)(b), Florida Statutes, when it unlawfully applied the assignor's No Fault deductible, and when it paid claims out of order. As such, these allegations created genuine issues of material fact as to whether the Appellee engaged in improper and/or bad faith claims handling, which should have been determined by a jury. Additionally, the Appellant argues that the trial court incorrectly concluded that its assertions of bad faith are unsubstantiated because it did not file a civil remedy notice, which is a condition precedent to filing a bad faith action. The Appellant asserts that there is no support for the position that, in order to avoid an exhaustion of benefits defense based on bad faith claims handling, a medical provider must first comply with the statutory and procedural requirements of section 624.155, Florida Statutes. A bad faith claim brought under section 624.155, Florida Statutes, and an allegation of bad faith to avoid an exhaustion of benefits defense are two completely different legal theories.[3] There is no case that states that in order for a medical provider to avoid an exhaustion of benefits defense by alleging bad faith, the medical provider must first file a civil remedy notice, then must obtain a judgment in excess of the policy limits, and then file a separate action for bad faith damages. The Appellant contends that to hold otherwise would be a derogation of *Stand-Up MRI* and *Northwoods*, both of which require the issue of liability and bad faith to be litigated simultaneously.

[3] Appellant's Notice of Supplemental Authority cites to the Seventh Judicial Circuit county court case of *Emery Med. Solutions a/a/o Jayne Hartnett v. State Farm*, Case No. 2018 10958 CODL (Fla. Volusia Cty. Ct. Nov. 27, 2018). This case stands for the proposition that a bad faith claim filed in response to an exhaustion of benefits defense does not have to comply with section 624.155, Florida Statutes. The court found that the bad faith claim was merely an avoidance of the defendant's affirmative defense that benefits are exhausted, which is only an allegation and not a statutory bad faith action. Because the plaintiff was not seeking extra contractual damages, section 624.155, Florida Statutes, did not control the plaintiff's allegation, which must be decided in conjunction with the defendant's claim that benefits are exhausted.

On the contrary, the Appellee argues that an insurer's alleged bad faith is not an exception to the exhaustion of benefits defense because those allegations have no effect on the insured's contractual obligations to pay no more than $10,000 in PIP benefits. Additionally, the Appellee argues that there is no binding authority to support the proposition that bad faith is an exception to the exhaustion of benefits defense. Rather, courts have only held that, absent bad faith, an insurer cannot be liable for amounts in excess of the policy limits.[4] Thus, once benefits exhaust, allegations of bad faith have no effect on the amount of insurance benefits for which the insurer may be liable, within the terms of the policy. Moreover, the Appellee asserts that it had the statutory authority and duty to its insured to refrain from paying any amounts it deemed not compensable. As such, the Appellee argues that final summary judgment was proper because it fulfilled all of its contractual obligations – it paid $10,000 in PIP benefits on behalf of the insured.

In 1982, the Florida Legislature created a first-party bad faith cause of action by enacting section 624.155, Florida Statutes, thereby imposing a duty on insurers to settle their policyholders' claims in good faith.[5] The statute was "designed and intended to provide a civil remedy for any person damaged by an insurer's conduct." *Demase v. State Farm Fla. Ins. Co.*, 239 So. 3d 218, 220 (Fla. 5th DCA 2018). Specifically, section 624.155(1)(a) provides that "[a]ny person may bring a civil action against an insurer when such person is damaged" by a violation by the insurer of certain statutory provisions. As a condition to bringing such a bad faith action, Florida's Department of Financial Services and the insurer must be given sixty days' written notice of the claim. *See* § 624.155(3)(a), Fla. Stat. (2015). "The sixty-day window is designed to be a cure

[4] The Appellee cites to the following cases to support this proposition: *Geico Indem Co.*, 159 So. 3d at 155; *Northwoods*, 137 So. 3d at 1057; *Stand-Up MRI*, 990 So. 2d at 5.

[5] In section 624.155, Florida Statutes, the legislature created a statutory cause of action for first-party bad faith, as well as third-party bad faith. *See McLeod v. Cont'l Ins. Co.*, 591 So. 2d 621, 623 (Fla. 1992), superseded by statute as stated in *Time Ins. Co., Inc. v. Burger*, 712 So. 2d 389 (Fla. 1998).

period that will encourage payment of the underlying claim, and avoid unnecessary bad faith litigation." *Demase*, 239 So. 3d at 221. This cure period allows the insurer "a final opportunity to comply with their claim-handling obligations when a good-faith decision by the insurer would indicate that contractual benefits are owed." *Fridman v. Safeco Ins. Co. of Ill.*, 185 So. 3d 1214, 1220 (Fla. 2016) (citation omitted). "[I]f an insurer fails to respond to a civil remedy notice within the sixty-day window, there is a presumption of bad faith sufficient to shift the burden to the insurer to show why it did not respond." *Id.* (citation omitted). Hence, a statutory bad faith claim under section 624.155 is ripe for litigation when there has been: (1) a determination of the insurer's liability for coverage; (2) a determination of the extent of the insured's damages; and (3) the required notice is filed pursuant to section 624.155(3)(a). *Demase*, 239 So. 3d at 221; *see also Vest v. Travelers Ins. Co.*, 753 So. 2d 1270 (Fla. 2000). However, an underlying action on the insurance contract is not required for there to be a determination of the insurer's liability and the extent of the damages as a prerequisite to filing a statutory bad faith action. *Demase*, 239 So. 3d at 220. An insured, in seeking to bring a bad faith claim against an insurer, may obtain a determination of the insurer's liability and the extent of their damages by litigation, arbitration, settlement, stipulation, or the payment of full policy limits. *Id.* at 223-24.

Contrary to the Appellant's arguments, *Stand-Up MRI of Orlando* and *Northwoods* do not require that the issue of liability and bad faith must be litigated simultaneously. As previously stated, "[b]oth the existence of liability and the extent of damages are elements of a statutory cause of action for bad faith that must be determined before a statutory cause of action for bad faith will lie." *Vanguard Fire and Cas. Co. v. Golmon*, 955 So. 2d 591, 594 (Fla. 1st DCA 2006). This is because the Appellee would clearly be prejudiced by having to litigate a bad faith claim in tandem with a coverage claim because the evidence used to prove the bad faith allegation could well

jaundice the jury's view of the coverage issue. *Hartford Ins. Co v. Mainstream Const. Group, Inc.*, 864 So. 2d 1270, 1272 (Fla. 5th DCA 2004) (quoting *Blanchard v. State Farm Mut. Ins. Co.*, 575 So. 2d 1289, 1291 (Fla. 1991)); *see also Vanguard*, 955 So. 2d at 594; *Old Republic Nat'l Title Ins. Co. v. HomeAmerican Credit, Inc.*, 844 So. 2d 818, 819 (Fla. 5th DCA 2003) (holding that litigation of the coverage and bad faith claims simultaneously is also inappropriate because discovery regarding the bad faith claims handling is not available to the complainant until after coverage and liability is determined).[6] If the Appellant had such a claim, it should have been pursued in a separate action and could not serve as a basis for liability. Thus, there must first be a determination regarding the coverage and contractual dispute between the parties before an action for bad faith can proceed.

We recognize that the law concerning this issue is scattered and somewhat unclear, leaving a gray area for the litigants and the court; perhaps this is a question to be addressed by the District Court. Additionally, it is true that whether an insurer engaged in improper or bad faith claims handling is a question for the jury. *See Farinas v. Fla. Farm Bureau Gen. Ins. Co.*, 850 So. 2d 555, 561 (Fla. 4th DCA 2003). However, while the case law recognizes that a showing of bad faith is required before the insurer can be held liable for benefits above the statutory limit, we are unable to find any case law that specifically stands for any of the following propositions that would support the Appellant's arguments: 1) bad faith is an exception to an exhaustion of benefits defense, 2) the issue of liability and bad faith must be litigated simultaneously, wherein the jury will determine whether the insurer engaged in improper or bad faith claims handling, and 3) the medical provider must first file a civil remedy notice, then obtain a judgment in excess of the

[6] *See also Allstate Indem. Co. v. Ruiz*, 899 So. 2d 1121, 1130 (Fla. 2005) ("[L]itigants who choose to file both actions simultaneously must recognize that certain documentation relevant to the bad faith action may not be available for discovery until after resolution of the underlying matter.").

policy limits, and then file a separate action for bad faith damages. If a litigant was permitted to bring a PIP coverage and contract action along with a claim or allegation of improper and/or bad faith claims handling, it would render section 624.155 meaningless. It is illogical to interpret this section in such a manner, as that would mean that the Legislature intended that litigants could permissibly bypass the statute and not comply with the procedural framework set forth therein. Moreover, the Appellant did not claim or allege bad faith in its initial or Amended Complaint. It raised the issue of bad faith as a reply to the Appellee's affirmative defense of exhaustion of benefits.[7] This route was inappropriate in the context of bad faith and improper claims handling. If the Appellant thought that the medical bills were processed improperly or in bad faith, the Appellant should have complied with the statutory framework and filed the civil remedy notice.

The Appellant's allegations concerning bad faith, at best, do no more than question the Appellee's exercise of judgment in determining and reducing the amounts of the medical bills. Bad judgment does not, in our opinion, equate with bad faith. *See generally Sharpe v. Physicians Protective Trust Fund*, 578 So. 2d 806, 808 (Fla. 1st DCA 1991). Given the broad discretion that must be accorded to the insurer in the disposition of claims, we will not second guess a legitimate judgment call, even if questionable. Thus, the trial court properly rejected the Appellant's arguments concerning the issue of bad faith.[8]

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[7] The Appellant also argues that the Appellee failed to establish conclusively that it did not act improperly or in bad faith. The Court finds that the argument is without merit and it makes no difference because the Appellee did not have to conclusively refute the allegation of bad faith. That allegation or claim was unsubstantiated because the Appellant did not comply with the procedural framework of section 624.155, Florida Statutes.

[8] *See generally Portofino South Condo. Ass'n v. QBE Ins. Corp.*, 664 F.Supp.2d 1265 (S.D. Fla. 2009) (concluding that under Florida law a cause of action for breach of the implied warranty of good faith and fair dealing is subsumed in a bad-faith action pursuant to section 624.155); *Nirvana Condo. Ass'n v. QBE Ins. Corp.*, 589 F.Supp.2d 1336, 1342 (S.D. Fla. 2008) (dismissing a contractual claim for breach of implied warranty of good faith and fair dealing "as a matter of law" because the insured's "relief for the unreasonable or untimely payment of its claim is limited to a section 624.155 action that does not ripen until [the coverage] litigation is concluded"); *QBE Ins. Corp. v. Dome Condo. Ass'n*, 577 F.Supp.2d 1256, 1261 (S.D. Fla. 2008) (dismissing a claim for breach of the implied covenant of good faith and fair dealing because "no such cause of action exists under Florida law"); *cf. Trief v. Am. Gen. Life Ins. Co.*, 444 F.Supp.2d 1268, 1270 (S.D. Fla. 2006) (describing plaintiff's allegations regarding insurer's failure to adjust,

II. Whether Appellee should have paid the claims pursuant to the English Rule of Priorities, thereby creating a genuine issue of material fact as to the compensability of the claims.

The Appellant contends that the Appellee violated the English Rule by failing to fully pay its bills before paying the undisputed bills of the insured's other medical provider. It argues that the Appellee admitted that it violated section 627.736(4)(b), Florida Statutes, when it did not timely pay the claims and did not have reasonable proof that it was not responsible for payment. It asserts that the unpaid claims are overdue and compensable; therefore, the English Rule of Priorities applied to the unpaid claims.

The Appellee argues that the application of the English Rule to PIP claims is limited because PIP claims are governed by statute. It contends that it only applies to amounts that are deemed compensable; however, claims that are disputed by insurers are not subject to the English Rule. It asserts that it reduced the Appellant's claims and applied the deductible in a manner that was disputed by the Appellant; therefore, the English Rule does not apply here.

Under PIP, disputes commonly arise as to the amount due to the provider assignee, based on the policy language or the PIP statutory provisions. The insurance company has the duty to pay only the reasonable expenses for medically necessary care. *See* § 627.736(1)(a), Fla. Stat. (2015). A medical provider may charge only a reasonable amount for services provided under section 627.736(5)(a), Florida Statutes (2015). For this reason, the application of the English Rule to PIP claims is limited because PIP claims are governed by statute. *Northwoods*, 137 So. 3d at 1054-55; *Sheldon*, 55 So. 3d at 595; *Stand-Up MRI*, 990 So. 2d at 5; *Simon*, 904 So. 2d at 449-50. To the extent that the English Rule does apply to PIP claims, it only applies to amounts that are deemed

investigate, and pay claim as "resembl[ing] a claim for statutory bad faith rather than one for breach of implied obligation of good faith" and dismissing it as premature until the underlying coverage dispute was determined).

compensable, in that they have been determined to be reasonable and necessary. *Northwoods*, 137 So. 3d at 1055; *Stand-Up MRI*, 990 So. 2d at 6.

Claims that are disputed by insurers are not subject to the English Rule:

> Applying the English Rule to PIP claims results in the very outcome that the court in *Simon* sought to prevent. Holding funds in reserve until the completion of litigation is detrimental to everyone except the provider(s) who is keeping the funds tied up. It subjects the insurer to unreasonable exposure, is detrimental to other providers with properly submitted claims, and detrimental to the insured who is entitled to both prompt treatment and prompt payment for that treatment. Furthermore, it is contrary to the legislative intent to have these bills quickly paid. *See Ivey v. Allstate Ins. Co.*, 774 So. 2d 679, 683-84 (Fla. 2000) ("Without a doubt, the purpose of the no-fault statutory scheme is to 'provide swift and virtually automatic payment so that the injured insured may get on with his life without undue financial interruption.' ").
>
> If allowed to stand, the circuit court's ruling would require insurers to pay insurance benefits in excess of the stated policy limit, even after the insurer fully complied with the duties owed to its insured. This outcome is not supported by the statute and violates every principle of law governing insurance contracts.

Stand-Up MRI, 990 So. 2d at 6. Indeed, citing to *Stand-Up MRI of Orlando*, we have unequivocally held that the English Rule does not apply to a disputed PIP claim. *See Progressive Express Ins. Co. v. Barton Lake Healthcare Ctrs.*, 16 Fla. L. Weekly Supp. 1125a (Fla. 9th Cir. Ct. Oct. 7, 2009). Inherent in the reasoning of the aforementioned cases is that when there is a dispute about the reasonableness of the charges, compensability is not established.

Here, the Appellee reduced the amount of the Appellant's claims and applied the deductible in a manner that is disputed by the Appellant. The insurance policy elects the fee schedule, which states that any amount over the fee schedule is determined to be unreasonable. The Appellee issued payment in response to both pre-suit demand letters. As such, these claims were not deemed to be compensable from the outset. Every single bill that was paid was reduced. By the very nature of the fact that the claims were reduced, it means that they were not compensable. As applicable to the instant case and sufficiently stated by the Fourth District Court of Appeal:

> When the insurance company denies or reduces payment, a dispute arises as to whether the additional amounts are covered by the statute as being either medically necessary or reasonable in amount. Section 627.736(4) sets forth very specific requirements on how the insurance company must treat claims of providers. Even after a claim is denied or reduced, an insurance company may still defend a suit by the provider claiming additional amounts on the grounds that the service was not medically necessary or that the amount was not reasonable. *See* § 627.736(4)(b), Fla. Stat. (2008); *Rodriguez*, 808 So. 2d at 87–88.
>
> Until the necessity of the services and reasonableness of the charges is settled, their compensability under PIP is not established, and assignment of PIP benefits has not matured. Thus, the English Rule would have application only to those claims which are settled either by insurance company acceptance or by resolution of disputed charges through suit.
>
> We hold that post-suit exhaustion of benefits should be treated no differently than pre-suit exhaustion of benefits, as long as the benefits' compensability under PIP has not been established. Once the PIP benefits are exhausted through the payment of valid claims, an insurer has no further liability on unresolved, pending claims, absent bad faith in the handling of the claim by the insurance company.

Northwoods, 137 So. 3d at 1057. Likewise, the order in which the Appellee paid the claims is not relevant because the Appellant provided no record evidence to show it should or would have received more than the $8,342.16 in PIP benefits it ultimately received. Thus, the Appellant has no damages.[9] The Court finds that the trial court properly rejected the Appellant's arguments concerning the issue of applying the English Rule of Priorities.

III. Whether a genuine issue of material fact existed as to whether the Appellee made gratuitous payments to the Appellant.

The Appellant contends that the Appellee's payment of benefits for subsequent claims were gratuitous and should not count toward the assignor's pool of benefits. The Appellant's position is that its entitlement to payment for dates of service November 14, 2014, through December 10, 2014, December 12, 2014, through January 6, 2015, as well as January 8, 2015, through February

[9] The Court notes that it is now settled that the proper method of applying a PIP insurance policy deductible to a medical provider's bill for hospital emergency services and care is to subtract the deductible from the assignee's charges before applying the reimbursement limitation. *See Progressive Select Ins. Co. v. Fla. Hosp. Med. Ctr.*, 2018 WL 6816810 (Fla. Dec. 28, 2018).

2, 2015 was established as soon as the claim became overdue. As such, any benefits that the Appellee paid for subsequent claims after the subject claims were overdue, and that were necessary to satisfy the Appellant's overdue claims, were gratuitous payments. The Appellant cites to *Coral Imaging Servs. v. Geico Indem. Ins. Co.*, 955 So. 2d 11 (Fla. 3d DCA 2006) and *Progressive Express Ins. Co. v. South Fla. Institute of Medicine, Inc.*, 14 Fla. L. Weekly Supp. 520a (Fla. 11th Cir. Ct. Apr. 11, 2007) for support. The Appellant points to the fact that the Appellee's corporate representative admitted in his deposition that the Appellee should have paid the Appellant for dates of service January 8, 2015, through February 2, 2015, prior to issuing payment for dates of service February 4, 2015, through March 2, 2015. The corporate representative continued by admitting that they would have been flipped, and the exhaustion would have been on the second bill. The corporate representative confirmed that the proper payment should have been the full payment of dates of service January 8, 2015, through February 2, 2015 and exhaustion being issued to dates of service February 4, 2015, through March 2, 2015.

The Appellee argues that it defies logic to make the argument that because it was obligated to pay the earlier bills, it was not obligated to pay the later bills and the payment of those later bills was therefore gratuitous. The fact that the later bills were paid is inconsequential because the Appellant received the entire "pizza pie" of payments. The Appellee asserts that all of the claims of both providers were paid timely and both providers were entitled to payment. The Appellee contends that no payment was gratuitous because it cannot be liable for additional PIP benefits, as it fully satisfied its obligations to its insured by paying the full extent of the $10,000 in PIP coverage to the Appellant and the insured's other medical provider.

The Appellant's reliance on *Coral Imaging* and *Progressive Express* is misplaced. In *Coral Imaging*, the plaintiff provided medical services to a PIP insured and timely submitted its bill to

the insurer. 955 So. 2d at 12. The insurer denied the claim and Coral Imaging sued the insurer, arguing that the insurer's payment of the untimely bills of another provider, Professional Reading, was improper, and should not have counted toward exhausting the $10,000 PIP benefits. *Id.* at 12-13. The court agreed and held that, under the circumstances of that case, the plaintiff's entitlement to have its bill paid was not barred by the fact that the insurer had already paid out $10,000 to the insured's medical providers. *Id.* at 13-16. The court noted that section 627.736(5)(c) required a medical provider to postmark its bill to the insurer no later than thirty (30) days after the service was rendered.[10] *Id.* at 13. The court also noted that the statute prohibited a provider from billing for services rendered more than thirty (30) days from the postmark of the bill, and provided that an insurer "is not required to pay" for those services. *Id.* In addition, the court held that, had the insurer not paid the untimely bill of Professional Reading, pursuant to section 627.736(5)(c), the insured would have not responsibility to pay it. *Id*. a 13-14. Thus, those funds would have been available to pay the plaintiff's timely submitted bill, for which the insured was responsible:

> [U]pon exhausting the PIP benefits by paying Professional Reading, and denying payment to Coral Imaging on its timely bill, Coral Imaging is now permitted to seek payment from the insured because it complied with the statutory 30-day time requirement. If, on the other hand, Geico chose (or was duty-bound by statute) to deny Professional Reading's untimely bill (therefore allowing Geico to pay Coral Imaging's timely bill . . .), Professional Reading would have no recourse against the insured . . .

Id. at 15.

In *Progressive Express*, the insurer exhausted benefits long after the medical provider filed its lawsuit against the insurer and the court ruled against the insurer based on its assessment that *Simon* does not address the issue of whether funds should be held in reserve where they have not been exhausted when the insurance company is on notice of a contested claim. *Id*. Subsequent to

[10] The 1999 version of the statute at issue in *Coral Imaging* set a 30-day time limit. The version of the statute at issue in the instant case provides a 35-day time limit.

the issuance of the opinion, the Fifth District Court of Appeal decided *Stand-Up MRI* and clearly held that in a case where the insurer was on notice of the contested claim at the time it exhausted benefits, the insurer could not be liable to the plaintiff after the benefits had exhausted. 990 So. 2d at 7-8. As such, *Progressive Express* is no longer good law.

As previously stated, the order in which the Appellee paid the claims is not relevant because the Appellant would not have received more than $8,342.16 in PIP benefits – it received the whole "pizza pie." Importantly, all of the Appellant's and Precision Diagnostics' bills were submitted timely, and both providers were entitled to payment. In sum, *Coral Imaging* is not applicable to the instant case and only applies where an insurer pays an untimely bill ahead of a timely one.[11] Unlike the payment of the untimely bill in *Coral Imaging*, here, no payment made to the Appellant or Precision Diagnostics was gratuitous.

The "Order Granting Final Summary Judgment," entered on June 30, 2017, is **AFFIRMED**. The Appellant's "Motion for Attorney's Fees" is **DENIED**. The Appellee's "Motion for Attorney's Fees" is **GRANTED**, and the assessment of those fees is **REMANDED** to the trial court.[12]

DONE AND ORDERED in Orlando, Orange County, Florida this _____day of January, 2019.

GAIL A. ADAMS
Presiding Circuit Judge

JORDAN and MARQUES, JJ., concur.

[11] *See also Geico*, 159 So. 3d at 155 holding that:

> *Coral Imaging* only applies where the PIP insurer exhausts benefits by improperly paying untimely claims. *Coral Imaging*, 955 So. 2d at 12. Here, in contrast, benefits were not improperly exhausted. Rather, every medical provider GEICO paid on behalf of Lauzan was entitled to payment and all the claims paid were timely.

[12] *See* section 768.79, Florida Statutes and *Frosti v. Creel*, 979 So. 2d 912 (Fla. 2008).

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing order has been furnished to: **The Honorable Eric H. DuBois**, Orange County Judge, Orange County Courthouse, 425 N. Orange Ave., Orlando, Florida 32801; **Chad A. Barr, Esq.**, Attorney for Appellant, **Law Office of Chad A. Barr, P.A.**, 986 Douglas Avenue, Suite 100, Altamonte Springs, Florida 32714; and **Kenneth P. Hazouri**, Attorney for Appellee, **deBeaubien, Simmons, Knight, Mantzaris & Neal, LLP, d/b/a DSK Law**, 332 N. Magnolia Avenue, Orlando, Florida 32801, this _____ day of January, 2019.

_____
Judicial Assistant