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

CASE NO.: 2015-CV-000095-A-O

FULMORE & ASSOCIATES CHIROPRACTIC AND SPINAL INJURY CENTERS, PA a/a/o JENNIFER JOHNSON,

Appellant,

v.

ENTERPRISE LEASING COMPANY OF ORLANDO, LLC,

Appellee.
___________________________________/

Appeal from the County Court of
Orange County, Florida
Jeanette Dejuras Bigney, County Court Judge

Chad A. Barr, Esquire,
for Appellant.

David C. Borucke, Esquire,
for Appellee.

Before DOHERTY, TURNER, and WOOTEN, J.J.

PER CURIAM.

Appellant, Fulmore & Associates Chiropractic and Spinal Injury Centers, PA ("Appellant"), timely appeals the county court's "Order Denying Plaintiff's Motion for Attorney's Fees and Costs," dated August 5, 2015, in favor of Enterprise Leasing Company of Orlando, LLC "Appellee." This Court has jurisdiction pursuant to section 26.012(1), Florida Statutes, and Florida Rule of Appellate Procedure 9.030(c)(1)(A). We dispense with oral argument and affirm. Fla. R. App. P. 9.320.

Facts

On February 28, 2013, Jennifer Johnson was involved in an auto accident while riding as a passenger in one of Appellee's rental vehicles. Pursuant to Appellee's rental agreement, under the circumstances in this case, Appellee agreed to extend personal injury protection ("PIP") benefits to Ms. Johnson. As a result of the accident, Ms. Johnson received medical treatment from Appellant between April 18, 2013, and September 20, 2013. Upon receiving treatment, Ms. Johnson assigned her PIP benefits to Appellant.

Taking the position that Ms. Johnson's benefits were capped at $2,500.00, as of June 4, 2013, Appellee paid up to that amount, but denied further payment for Ms. Johnson's medical treatment. Appellant, however, continued to submit bills to Appellee. In response, Appellee sent six letters to Appellant, quoting section 627.736(1)(a)4, Florida Statutes, and indicating that, "[b]ased on the medical records, [Ms. Johnson] did not have an emergency medical condition. PIP benefits for this patient have been exhausted based on the above referenced statute and no further payments will be issued." Each letter invited Appellant to contact Appellee, via telephone, should it disagree with this determination or have any questions regarding coverage. Appellant elected not to contact Appellee via telephone. Rather, on March 7, 2014, Appellant sent a demand letter seeking further benefits. Appellee, still asserting that there was no record of an EMC diagnosis, continued to refuse payment, and on April 9, 2014, Appellant filed suit.

Apparently unbeknownst to Appellee, on April 18, 2013, Doctor Andrew Akerman of TeleMed America examined Ms. Johnson and concluded that she did indeed have an emergency medical condition ("EMC"). At an evidentiary hearing on Appellant's motion seeking attorney's fees, Appellant maintained that it submitted Dr. Akerman's report to Appellee on two occasions prior to filing this lawsuit, once shortly following the examination (though no specific date was

provided) and once on July 10, 2013. However, beyond an affidavit filed two weeks after the hearing and one day after execution of the order denying fees, Appellant provided no evidence that it mailed, or that Appellee received, Dr. Akerman's report. On the contrary, at the evidentiary hearing, Appellee provided an affidavit affirming that it did not learn of Dr. Akerman's report and determination that Ms. Johnson suffered an EMC until March 3, 2015, in response to a request for production and almost one year into the lawsuit. Tellingly, three of the six letters that Appellee sent to Appellant claiming that it had no record of an EMC determination, were sent after July 10, 2013.[1]

On March 31, 2015, within 30 days of receiving the discovery response with Dr. Akerman's report, Appellee remitted payment for the outstanding medical bills. In response, Appellant sought attorney's fees and costs, purporting that Appellee's payment was a confessed judgment, rendering Appellant a prevailing insured (or an assignee of a prevailing insured) entitled to fees in accordance with section 627.428, Florida Statutes.[2]

Although the court ultimately entered a written order, it announced its ruling at the conclusion of the evidentiary hearing, explaining:

> Both sides have argued it's a confession of judgment issue. And ultimately tendering payment equals a confession of judgment. However, the Court is relying upon the Omega case, which also cites to the Lorenzo case. And I want to go ahead and read this in part onto the record. "For a *[sic]* confession of judgment doctrine to apply, the insurer must have unreasonably withheld payment under the policy or engage *[sic]* in some other wrongful behavior that forced the insured to sue."

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[1] At the evidentiary hearing, Appellee submitted letters it sent to Appellant on the following dates: June 4, 2013, June 19, 2013, June 25, 2013, August 1, 2013, September 23, 2013, and April 3, 2014.

[2] Section 627.428 provides in pertinent part:

> Upon the rendition of a judgment or decree by any of the courts of this state against an insurer and in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer, the trial court or, in the event of an appeal in which the insured or beneficiary prevails, the appellate court shall adjudge or decree against the insurer and in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured's or beneficiary's attorney prosecuting the suit in which the recovery is had.

> The Court is finding that there was no wrongful behavior or unreasonable withhold of payment. Now, what I have to go on clearly is the record evidence. And I have plaintiff's exhibits and defense exhibits. There is one letter dated in July, which defense denies seeing. But it's one letter saying there was an emergency - - emergency medical condition. Outweighed by defense Exhibit D, which asks for more documentation in saying nothing in their documents state that they're acknowledging it's an emergency medical condition and plaintiff did nothing to overcome that.
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> Upon finally receiving it in Request to Produce, it seems that there was timely payment. . . . the Court is making a finding that the payment was timely and quickly made by the defendant. So for those reasons, I'm going to go ahead and deny the Plaintiff's Motion for Attorney's Fees.

Arguments on Appeal

On appeal, Appellant contends that, upon Appellee's payment of the outstanding medical bills, Appellant's entitlement to attorney's fees was automatic such that the county court had no discretion to deny its motion. According to Appellant, because Appellee paid the outstanding bills after the initiation of this lawsuit, the payment constituted a confession of judgment, and therefore, attorney's fees are mandatory under section 627.428, Florida Statutes.

Appellee responds that, the county court's findings are supported by competent, substantial evidence and that, its payment was not a confession of judgment because Appellee did not wrongfully or unreasonably deny benefits forcing Appellant to file suit. According to Appellee, the subject lawsuit was immature, and it timely paid the benefits upon receiving notice of the EMC determination. Only upon receipt of such determination, Appellee maintains, did it have an obligation to pay additional benefits. For the reasons articulated below, we agree with Appellee and uphold the county court's denial of attorney's fees.

Standard of Review[3]

Our review of the county court's order involves questions of both fact and law; it concerns first, whether the county court appropriately found that Appellee did not wrongfully or unreasonably deny PIP benefits, and second, whether the court, as a matter of law, correctly concluded that Appellee's payment of benefits was not a confession of judgment. "[M]ixed questions of fact and law require the application of two different standards of review. The factual findings must be supported by competent, substantial evidence, while legal findings are reviewed de novo." *Klinow v. Island Court at Boca W. Prop. Owners' Ass'n, Inc.*, 64 So. 3d 177, 180 (Fla. 4th DCA 2011) (internal citation omitted). *See also Teffeteller v. Dugger*, 734 So. 2d 1009, 1017 (applying the competent, substantial evidence test to review of factual findings at evidentiary hearings); *Hamilton v. Florida Power & Light Co.*, 48 So. 3d 170, 172 (Fla. 4th DCA 2010) ("When there is a nonjury finding on disputed evidence, it is reviewed on appeal for competent, substantial evidence.").

Analysis

Section 627.736, Florida Statutes, governs PIP benefits and mandates coverage, regardless of fault, for certain reasonable medical expenses "up to $10,000 if a physician . . . has determined that the injured person had an emergency medical condition;" otherwise, "[r]eimbursement for services and care provided . . . is limited to $2,500 if a provider . . . determines that the injured person did not have an emergency medical condition." § 627.736(1)(a) 3-4. The parties concede that, given Dr. Akerman's determination, Ms. Johnson suffered an EMC and was entitled to benefits up to $10,000.00. They disagree, however, over whether the circumstances here

[3] Appellant argues that the applicable standard of review is de novo; while Appellee maintains our review should concern whether the decision below is supported by competent, substantial evidence. The panel adopts of mixed review standard, as our analysis concerns both findings of fact and questions of law.

warranted application of the confession of judgment doctrine and entitled Appellant to attorney's fees under section 627.428, Florida Statutes.

Section 627.428, Florida Statutes, mandates the award of attorney's fees to insureds who prevail in litigation with their insurers over policy benefits. "Its purpose is to discourage insurers from contesting valid claims and to reimburse successful insureds for attorney's fees when they must sue to enforce their insurance contracts." *State Farm Florida Ins. Co. v. Lorenzo*, 969 So. 2d 393, 397 (Fla. 5th DCA 2007). "'By using the legal fiction of a confession of judgment, our supreme court extended the statute's application' to cases in which the insurer settles or pays a disputed claim before rendition of judgment." *Tampa Chiropractic Ctr., Inc. v. State Farm Mut. Auto. Ins. Co.*, 141 So. 3d 1256, 1258 (Fla. 5th DCA 2014) (quoting *Basik Exports & Imports, Inc. v. Preferred Nat'l Ins. Co.*, 911 So. 2d 291, 293 (Fla. 4th DCA 2005)). This is because "[when the insurance company has agreed to settle a disputed case, it has, in effect, declined to defend its position in the pending suit." *Wollard v. Lloyd's & Companies of Lloyd's*, 439 So. 2d 217, 218 (Fla. 1983).

Contrary to Appellant's assertions, however, application of the confession of judgment doctrine is neither automatic nor absolute. Appellant would have this Panel conclude that any payment of benefits occurring after a lawsuit is filed constitutes a confessed judgment as a matter of law. "However, when the insured utilizes the confession of judgment doctrine, the underlying issue is not when the insurer paid the claims, but if the insured was forced to litigate in order to get the insurer to pay the claim." *State Farm Florida Ins. Co. v. Lime Bay Condo., Inc.*, 187 So. 3d 932, 934 (Fla. 4th DCA 2016).

For the doctrine to apply, "the insurer must have unreasonably withheld payment under the policy, or engaged in some other wrongful behavior that forced the insured to sue." *Tampa*

Chiropractic Ctr., 141 So. 3d at 1258. Thus, when tasked with determining whether to apply the confession of judgment doctrine, the pivotal inquiry concerns "whether 'the filing of the suit acted as a necessary catalyst to resolve the dispute and force the insurer to satisfy its obligations under the insurance contract.'" *Clifton v. United Cas. Ins. Co. of Am.*, 31 So. 3d 826, 829 (Fla. 2d DCA 2010) (quoting *First Floridian Auto & Home Ins. Co. v. Myrick*, 969 So. 2d 1121, 1124 (Fla. 2d DCA 2007)). *See also Omega Ins. Co. v. Johnson*, 39 Fla. L. Weekly D1911, at *4, review granted, 171 So. 3d 117 (2015). At a minimum, the insured must "clearly notify his or her insurer in a timely fashion of his or her dissatisfaction with the amounts paid." *Id*. at 831. If he or she fails to do so, the insured generally will be unable to show that he or she was 'forced' to file suit, and a subsequent post-suit payment by the insurer may not constitute a confession of judgment." *Id.*

Here, the county court found that Appellant did not demonstrate that it had made Appellee aware of the EMC determination. Unless and until it did that, there was no dispute and no wrongful denial of benefits forcing Appellant to file suit. *Id.* Once Appellee received notice of the EMC, the statute provided it 30 days "to verify whether the loss is payable or whether it is barred because of fraud or some other policy exclusion, and to determine whether the services provided and amount of the bill were reasonable or necessary." § 627.736(4)(b), Fla. Stat. (2015); *United Auto. Ins. Co. v. Stat Techs., Inc.*, 787 So. 2d 920, 922 (Fla. 3d DCA 2001). The evidence is undisputed that Appellee paid the claim within 30 days of receiving the March 3, 2015, notice of the EMC determination.

Additionally, competent, substantial evidence supports this finding. Appellee provided six letters indicating that its records did not reflect that Ms. Johnson suffered from an EMC and thus, its responsibility for payment of medical treatment was limited to $2,500.00. Although Appellant

claims to have mailed Dr. Akerman's report indicating an EMC, the county court determined that Appellee's evidence that it did not receive such report until March 3, 2015, well after suit was filed, outweighed Appellee's one piece of evidence – a single letter, dated July 10, 2013. Such was the county court's prerogative and not that of this panel. *See Shaw v. Shaw*, 334 So. 2d 13, 16 (Fla. 1976) ("It is not the function of the appellate court to substitute its judgment for that of the trial court through re-evaluation of the testimony and evidence from the record on appeal before it."); *Lime Bay Condo,* 187 So. 3d at 937 (reversing and remanding a summary judgment determination because whether the insured was forced to file suit was a genuine issue of material fact). Additionally, Appellant did not provide any evidence—aside from an affidavit filed after the county court had already ruled and executed a written order on the subject motion—that it actually sent Dr. Akerman's report to Appellee.

Appellant did not maintain below, nor could it, that, if it did not send Dr. Akerman's report indicating an EMC, Appellant would still be responsible for and wrongfully denied, benefits beyond $2,500.00. Indeed, both the Eleventh Circuit and the District Court for the Southern District of Florida have determined that section 627.736 "limits an insurer's obligation to provide personal injury protection benefits to $2,500, unless one of the medical providers listed in subparagraph (1)(a)(3) has determined that the injured person had an emergency medical condition." *Robbins v. Garrison Prop. & Cas. Ins. Co.*, 809 F.3d 583, 588 (11th Cir. 2015) (affirming *Robbins v. Garrison Prop. & Cas. Ins. Co.*, 62 F. Supp. 3d 1349, 1351 (S.D. Fla. 2014) and *Enivert v. Progressive Select Ins. Co.*, 62 F. Supp. 3d 1352, 1354-55 (S.D. Fla. 2014)). Stated differently, $2,500.00 is the default benefit cap, and when an insurer's record is silent as to whether or not an insured suffered an EMC, the insurer is to cap benefits at $2,500.00 unless and until it receives notice of an EMC determination. *Id.*

Perhaps Appellant said it best during the evidentiary hearing: "If my client did send the EMC to the insurance company, then we completely distinguish Omega. And I would concede that if we did not, then this is a very similar situation to Omega and that's the factual issue." (Hr'g T. 17, July 23, 2015). Whether Appellant notified Appellee of the EMC determination was a factual issue that the county court decided in favor of Appellee. The record supports this finding. Because Appellee did not wrongfully or incorrectly deny benefits to Appellant and thus did not force Appellant to file suit, Appellee's post-suit payment of additional benefits did not constitute a confessed judgment and did not entitle Appellant to attorney's fees under section 627.428.

Based on the foregoing, it is hereby **ORDERED AND ADJUDGED** that the "Order Denying Plaintiff's Motion for Attorney's Fees and Costs," dated August 5, 2015, is **AFFIRMED**.

DONE AND ORDERED in Chambers, at Orlando, Orange County, Florida, on this 21st day of July, 2016.

/S
PATRICIA A. DOHERTY
Presiding Circuit Judge

TURNER and WOOTEN, J.J., concur.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that, on this 21st day of July, 2016, a true and correct copy of the foregoing Order has been furnished to Jeanette Dejuras Bigney, *County Court Judge*, at 425 N. Orange Ave., Orlando, FL 32801; Chad A. Barr, Esq., *Counsel for Appellant*, at Law Office of Chad A. Barr, P.A., 698 North Maitland Ave., Suite 300, Maitland, FL 32751; and David C. Borucke, Esq., *Counsel for Appellee*, at Cole, Scott & Kissane, P.A., 4301 West Boy Scout Blvd., Suite 400, Tampa, FL 33607.

/S/
Stephani Quiroz, Judicial Assistant