Automobile Liability

Medical bills

Osceola County Board of County Commissioners v. Sand Lake Surgery Center, LLC, 320 So. 3d 950 (Fla. 5th DCA 2021)

The Plaintiffs claim they were injured when an elevator in the County's parking garage malfunctioned. Both were treated pursuant to letters of protection at Sand Lake. Rather than wait for the outcome of the Plaintiff's cases, Sand Lake sold the Plaintiffs' accounts receivables to American Medical Funding (AMF) which is a factoring company. The county used non-party production subpoenas to request Sand Lake to provide documents related to the Plaintiffs including their medical records, billing records, payments of their bills and records related to any sale of Plaintiffs' outstanding accounts to third parties.

Neither of the Plaintiffs objected to the subpoenas and Sand Lake responded to the subpoena by advising it had sold the Plaintiffs outstanding accounts to AMF and suggested that they obtain those records from AMF. The county then followed up by scheduling the deposition duces tecum of the Surgical Center's designated corporate representative and again requested similar documents. Neither Plaintiff objected and the Surgery Center provided medical treatment and billing records but stated that it was unable to provide documents related to payments or records reflecting the sale or transfer of any bills owed by the Plaintiffs because such information was subject to trade secret and confidentiality provisions and that a violation of this would subject Sand Lake to significant damages.

Eventually, a hearing was held and the trial court sustained the Surgical Center's objections. The Fifth District reversed and held that when a healthcare facility treats a personal injury Plaintiff, the Defendant being sued is entitled to discover the amount of the original medical bills and any discounts agreed upon when the healthcare facility sells the unpaid accounts to a factoring company because that information is relevant when the Plaintiff seeks to recover medical expenses as part of the lawsuit against the Defendant. The court also pointed out that the non-party respondents failed to carry their burden with establishing that the information sought was trade secret.

PIP

Rivera v. State Farm Mutual Automobile Insurance Company, 317 So. 3d 197 (Fla. 3d DCA 2021)

Rivera sued State Farm for a discrepancy in mileage payments under his PIP policy. Specifically, Rivera claimed that State Farm owed him $2.59 from under-payments. Rivera filed suit to which State Farm responded arguing that Rivera's presuit demand letter for the alleged transportation benefits owed failed to comply with Florida Statute §627.736(10) because it failed to "state with specificity or include an itemized statement specifying each exact amount, date of treatment, service or accommodation, and the type of benefits claimed to be due" while not taking into account payments made by State Farm in this claim. State Farm eventually moved for summary judgment, which was granted. The Third District affirmed noting that strict compliance with statutory requirements was necessary under the statute.

South Florida Pain & Rehabilitation of West Dade v. Infinity Auto Insurance Company, 318 So. 3d 6 (Fla. 4th DCA 2021)

Infinity paid the insured's assignee medical provider's claim for PIP benefits within 30 days after receipt of a pre-suit demand letter, but did not pay statutory penalties and postage costs. The Fourth District ruled that the assignee provider was not entitled to attorney's fees after it recovered a judgment solely for the statutory penalty and postage costs because the provider did not recover a judgment for PIP benefits.

Priority Medical Centers, LLC v. Allstate Insurance Company, 319 So. 3d 724 (Fla. 3d DCA 2021)

The Third District held that the trial court properly entered Summary Judgment in favor of the insurance company in a suit brought by a provider who brought a declaratory judgment action challenging the amount paid for an MRI after its own claims were denied because benefits had been exhausted.

Depositors Insurance Company v. Pasco-Pinellas Hillsborough Community Health System, 321 So. 3d 925 (Fla. 5th DCA 2021)

McKinney was involved in a motor vehicle accident in which her car was rear-ended by a pick-up truck while she was stopped at a red light. Thereafter, she drove herself to the emergency room at Florida Hospital where she presented with complaints of back pain. She underwent a CT scan, received a prescription for a muscle relaxer and was released from the hospital later that day. At the time of the accident, McKinney held an insurance policy with Depositors which provided her with PIP benefits. McKinney timely submitted an application for PIP benefits to Depositors. McKinney's policy closely tracked the substantive language contained in Florida Statute §627.736(1)(a)(3) which provides PIP benefits of up to $10,000 if a licensed physician, dentist or advanced registered nurse practitioner determined that the injured person had sustained an "emergency medical condition." The policy further provided that if a physician, dentist or advanced registered nurse practitioner determined that the injured person did not have an emergency medical condition then PIP benefits were limited to $2,500.

Following receipt of the claim for payment of PIP benefits, Depositor's sent a written request to Florida Hospital for a written determination as to whether McKinney had suffered an emergency medical condition resulting from her motor vehicle accident. Having received no response, Depositors limited its payment of PIP benefits to $2,500. As a result, Florida Hospital did not receive the full amount of monies for treating McKinney that it would have otherwise received had the available PIP benefits been $10,000. McKinney then assigned her rights under the policy to Florida Hospital. Florida Hospital then sued Depositors for breach of contract. The trial court entered Summary Judgment in favor of the hospital and the Fifth District reversed finding that there was no affirmative determination or diagnosis made that McKinney had suffered an emergency medical condition. As such, benefits were limited to $2,500 under the policy.

State Farm Mutual Automobile Insurance Company v. Stand Up MRI of Boca Raton, 322 So. 3d 87 (Fla. 4th DCA 2021)

Ramazio had an automobile insurance policy with State Farm that provided PIP coverage. On June 30, 2013, after he was involved in an automobile accident, Ramazio underwent three MRIs at Stand Up MRI. These MRIs were performed on the same date and were performed in exchange for an assignment of Ramazio's PIP benefits. Stand Up MRI billed State Farm a total of $4,800 and State Farm paid them a total of $2,551.16 based upon 200% of the 2007 Medicare Part B fee schedule and application of the Medicare Multiple Procedure Payment Reduction ("MPPR").

Stand Up MRI wrote State Farm objecting to the MPPR reduction and demanded additional payment. When State Farm did not make the additional payment, Stand Up MRI filed suit. The trial court ultimately granted a Motion for Summary Judgment in favor of Stand Up MRI.

The Fourth District reversed and ruled that the PIP statute did not preclude State Farm's method of reimbursing three MRIs that were conducted on the same day based upon its application of the MPPR. It further held that State Farm's insurance policy provided adequate notice of its intent to use Medicare coding policies and payment methodology such as the MPPR.

United Automobile Insurance Company v. Chiropractic Clinics of South Florida, 322 So. 3d 740 (Fla. 3d DCA 2021)

Chiropractic Clinics treated Michael Akins who was a passenger in a vehicle involved in an accident. The driver was the sister of the owner of the vehicle which was covered by a policy issued to the owner by United Automobile. United Automobile denied coverage and the patient was treated by Chiropractic Clinics under a letter of protection. Thereafter, it was determined that United Auto had wrongfully denied coverage. They then argued that they were not required to pay the bills submitted by Chiropractic Clinics because they did not submit them within 35 days of the rendition of the medical services. The Third District held that United Auto was equitably estopped from raising Chiropractic Clinic's failure to submit medical bills within 35 days of rendition of medical services or the failure to timely submit the medical bill was a result of United Auto's erroneously advising its insured that he had no PIP coverage and he relied on this misinformation to advise the clinic that he had no coverage.

State Farm Mutual Automobile Insurance Company v. Global Neuro and Spine Institute, 323 So. 3d 754 (Fla. 4th DCA 2021)

In 2015, Global Neuro filed a Complaint against State Farm for breach of contract. The Complaint alleged that Global treated an individual insured under a State Farm policy but that State Farm failed to timely make payments as required under the policy. Three years later, the county court issued an order setting pre-trial deadlines. The parties filed a Joint Pre-Trial Stipulation pursuant to this Order. The Joint Pre-Trial Stipulation listed the disputed issues of law in fact including "whether CPT Codes 77003A4550 were unbundled? (Plaintiff objects to this issue inclusion as an unpled defense, however, Defendant will be filing a copy of its Motion for

Leave to Amend Answer and Affirmative Defenses to plead unbundling as a defense)."

That same day, State Farm moved to amend its answer and Affirmative Defenses and the trial court denied the motion because the case had been pending since 2015 and because the pre-trial deadlines had passed. In reversing the trial court, the Fourth District stated that the trial court's reasons for denying the Motion for Leave to Amend including the pre-trial order and how long the case was pending can be relevant to a court's determination of prejudice or abuse of the amendment process, but without more, those reasons are insufficient to find prejudice or abuse of the process. The Fourth District concluded that State Farm had not abused the process of amending, the Plaintiff did not argue that the amendment would have been futile and there was no prejudice. As a result, the Fourth District reversed.

State Farm Mutual Automobile Insurance Company v. Baum Chiropractic Clinic, P.A., 323 So. 3d 756 (Fla. 4th DCA 2021)

Four years after State Farm answered the Plaintiff's complaint in a breach of contract action in which they did not assert any Affirmative Defenses, the trial court entered an order setting the case for trial and required the parties to file a pre-trial stipulation. The parties agreed that the lawsuit involved a determination of whether the treatment rendered was related to the accident, was medically necessary and was reasonable in price. Six days before trial, State Farm moved to amend to add several Affirmative Defenses including a set-off for PIP payments made pre-suit for services found not to be reasonable, related or medically necessary. The trial court denied the request to amend, and the Fourth District affirmed. In doing so, it stated that while Florida encourages a policy of liberality in allowing litigants to amend their pleadings, the policy narrows as the case approaches trial. Here, the case had been pending for four years yet State Farm did not decide to amend its pleadings until six days before trial.

United Automobile Insurance Company v. Progressive Rehabilitation and Orthopedic Services, LLC, 324 So. 3d 1006 (Fla. 3d DCA 2021)

Progressive Rehabilitation provided services to United Auto's insured due to injuries from a motor vehicle accident. The insured assigned his PIP benefits to the clinic. Eventually, the clinic filed a breach of contract action against United Auto for failure to pay PIP benefits. In its answer, United denied that the charges the clinic submitted for the services provided were reasonable. The clinic filed a Motion for Summary Judgment on the issue of reasonableness and attached an Affidavit of

the clinic's owner and corporate representative who asserted the charges were reasonable. Prior to the clinic filing its motion, United filed an affidavit of its claim adjuster who asserted that the charges were unreasonable. The clinic requested a *Daubert* hearing as to the adjuster's qualifications and basis of her opinions, following which the court struck the affidavit and granted summary judgment in favor of the clinic.

The Third District reversed pointing out that the *Daubert* standard does not prohibit expert opinion testimony based upon experience. As the court stated "nothing in the rule prohibits expert opinion testimony based on experience. Indeed, the plain language of §90.702 permits an expert to be qualified by 'knowledge, skill, experience, training or education…'"

United Automobile Insurance Company v. Central Therapy, Inc., 325 So. 3d 252 (Fla. 3d DCA 2021)

Following a motor vehicle accident, United Auto's insured sought treatment at Central Therapy. Thereafter, the insured assigned his benefits to Central Therapy which submitted bills to United Auto. Eventually, United Auto refused to pay some benefits and Central Therapy then sued alleging a breach of contract. United Auto answered and denied that the charges were reasonable, and that the treatment was reasonable, related and necessary.

Central Therapy filed a Motion for Summary Judgment and filed an Affidavit of a physician who opined that the charges were reasonable and within the range of usual and customary charges charged in the community for similar procedures. United filed an Affidavit of its adjuster who detailed her background, training and experience and her knowledge of monetary reimbursements by Florida PIP insurers providing reimbursement for medical services in South Florida. She then opined that the charges were not reasonable. The trial court found that the adjuster's Affidavit was legally insufficient because her opinions were not based on sufficient facts and data and therefore did not satisfy *Daubert*. The Third District reversed holding once again that the "*Daubert* standard does not prohibit…expert opinion testimony based on experience…indeed, the plain text of §90.702, Florida Statutes provides that experts may be qualified by 'knowledge, skill, experience, training, or education.'"

United Automobile Insurance Company v. Progressive Health Services, 325 So. 3d 1003 (Fla. 3d DCA 2021)

DeVaughn was insured by United Automobile. Following a motor vehicle accident, DeVaughn went to Progressive Health for treatment. Progressive Health billed United Automobile for services rendered to DeVaughn. Progressive Health received payment that it considered to be insufficient and filed a breach of contract action against United Automobile under an assignment from DeVaughn. As one of its defenses, United Automobile raised the unreasonableness of Progressive Health's charges pursuant to Florida Statute §627.736(5).

Progressive Health subsequently filed a Motion for Summary Judgment on the issue of the reasonableness of its charges accompanied by a supporting affidavit of its owner. United Automobile filed an opposing affidavit of its adjuster. In her affidavit, the adjuster provided the description of her training and experience along with the data she used in evaluating Progressive Health's charges. The trial court agreed with Progressive Health that its charges were reasonable and granted summary judgment and found that the adjuster's affidavit was insufficient as a matter of law because it solely presented conclusions of law without supporting facts and found the adjuster's opinions to be speculative. The Third District completed a *de novo* review of the record and concluded that the affidavit was neither speculative nor conclusory and that it was sufficient to create a genuine issue of material fact.

Star Casualty Insurance Company v. Gables Insurance Recovery, 326 So. 3d 813 (Fla. 3d DCA 2021)

Portal was injured in an automobile accident and sought medical treatment from Finlay Diagnostic Center and Aesculapius Medical. Portal assigned his PIP benefits under his policy with Star Casualty to these providers, each of whom later assigned their rights to Gables Insurance Recovery, Inc. Subsequently, Gables Insurance filed two separate lawsuits against Star Casualty for breach of contract based upon improper calculation of fee structure rates. Star Casualty confessed judgment in the Aesculapius case and the parties later entered into a settlement agreement. Following this settlement, the litigation involving Finlay Diagnostic continued for two years. Star Casualty then filed a Motion to Enforce the earlier settlement agreement asserting it had settled "all claims arising out of Portal's motor vehicle accident" including the claims raised in the Finlay Diagnostic litigation. Gables Insurance moved for sanctions and argued that the earlier settlement was solely for attorney's fees and costs related to the Aesculapius litigation and had nothing to do with the Finlay Diagnostic litigation.

The trial court conducted a non-evidentiary hearing at which time Star Casualty argued that the settlement agreement unambiguously encompassed both pending lawsuits and urged the trial court not to consider any parol evidence. Gables Insurance agreed that the court need not resort to parol evidence because there was no evidence of a "meeting of the minds" to settle the Finlay Diagnostic litigation. Alternatively, it argued that if the material terms of the agreement were ambiguous, the court could consider parol evidence in adjudicating the Motion to Enforce the settlement. Following argument by counsel, the trial court denied Star Casualty's Motion to Enforce the Settlement Agreement. Star Casualty then stipulated to a final judgment against it reserving its right to appeal the denial of its Motion to Enforce the Settlement.

On appeal, the Third District found that the language in the agreement contained a latent ambiguity such that it was necessary for the trial court to conduct an evidentiary hearing and consider parol evidence to determine the intent of the parties to the underlying settlement agreement.

Progressive American Insurance Company v. Head to Toe Posture Rehab, LLC, 326 So. 3d 1158 (Fla. 4th DCA 2021)

The Fourth District held that the plain language of Florida Statute §627.736(5)(a)(3) authorized the utilization of Medicare's Multiple Procedure Payment Reduction to limit PIP reimbursement for therapy services provided by a licensed chiropractor even though reimbursement to a chiropractor for those same services would not be provided for at all under Medicare.

State Farm Mutual Automobile Insurance Company v. M & E Diagnostic Services, Inc., 327 So. 3d 363 (Fla. 3d DCA 2021)

Pinelo was insured by State Farm. Following a motor vehicle accident, Pinelo sought treatment with M & E Diagnostic Services. M & E, as the assignee of Pinelo sued State Farm alleging that it underpaid M & E for services rendered to Pinelo following the accident. The parties stipulated that M & E's treatment to Pinelo was medically necessary and related to the accident. M & E moved for summary judgment regarding the reasonableness of its charges. In opposition to the motion, State Farm filed the affidavit of Dr. Dauer, who is a medical doctor and an owner of a diagnostic imaging center. He opined that M & E's charges were not reasonable. M & E moved to strike the doctor's affidavit arguing that Dr. Dauer's opinion was

pure opinion testimony based primarily on speculation and conjecture and failed to meet the *Daubert* test for admissibility. The trial court granted summary judgment and the Third District reversed. They noted that Dr. Dauer attested that he had personal knowledge and expertise regarding the range and rate of charges for medical care in the relevant community, including the range and rate of charges for radiological services provided in the area for patients by credentialed and experienced diagnostic centers and hospitals. Dr. Dauer then considered the reimbursement levels and charges in the community, his own charges in the community, various Federal and state medical fee schedules applicable to motor vehicles and other insurance coverages including worker's compensation, Medicare, HMOs, PPOs and other third-party insurance carriers, as well as the payments and reimbursements that M & E accepted from all sources. Dr. Dauer also attested to conducting numerous peer reviews and obtaining extensive personal knowledge and professional expertise regarding medical care and medical charges and reimbursements for Miami-Dade and Broward counties. The Third District found that Dr. Dauer's opinions satisfied Florida Statute §90.702 and was not pure opinion testimony based on speculation or conjecture. They explained that "pure opinion testimony is based solely on the expert's experience, without relation to the actual condition of the person in the relevant case."

United Automobile Insurance Company v. Stand-Up MRI of Miami, Inc., 327 So. 3d 386 (Fla. 3d DCA 2021)

On February 3, 2004, United Auto and Luis Perez entered into a contract for PIP insurance. Both Luis and his wife, Omaira Perez, were listed as insureds and the contract originally covered a 1993 Chevrolet Geo. This policy was amended on March 27, 2004 to include coverage on a 1993 Plymouth Voyager. The policy declaration page included an expiration date of February 3, 2005. On February 5, 2005, United Auto entered into a second insurance contract with Luis for personal injury protection coverage for a 1995 GMC Safari. Omaira Perez was also an insured on this policy. Of note, the policy listed the following exclusion: "this insurance does not apply…to the named insured or any relative while occupying a motor vehicle of which the named insured is the owner, and which is not an insured motor vehicle under this insurance."

On March 4, 2005, Omaira was involved in an automobile collision while driving the 1993 Plymouth Voyager. Also in the vehicle were the insureds' two minor children. Omaira and the children were treated at South Miami Health Center and Stand-Up MRI. Omaira assigned benefits to both medical providers which in

turn billed United Automobile for treatment. United Auto paid benefits to South Miami Health Center for all claims submitted and to Stand-Up MRI for claims for the children. United Auto denied their claim for Omaira's treatment at Stand-Up and, as a result, Stand-Up filed this action.

In response to Stand-Up's Complaint, United Auto asserted as an affirmative defense that "there is no coverage in that the subject loss is specifically excluded from coverage under the policy of insurance." United Auto then moved for summary judgment based upon the no-coverage defense. In opposition to the motion, Stand-Up argued that there was coverage on the Plymouth Voyager that pre-existed the coverage for the GMC Safari. While Stand-Up argued that the policy was still in effect, the document it provided in support indicated that the policy ended on February 3, 2005--one month before the subject date of loss. To support the assertion that the policy was still active, Stand-Up submitted an affidavit from the Bureau of Financial Responsibility stating that it was responsible for maintaining records of initiations and cancellations of all PIP insurance policies and according to their records, the policy issued by United Auto covering the Plymouth Voyager was still in effect on March 4, 2005. After investigating this affidavit, United Automobile submitted the affidavit of another employee from the state indicating that the policy covering the Voyager was cancelled prior to the crash. Eventually, the trial court granted Stand-Up's Motion for Summary Judgment finding that United Auto had waived its no-coverage defense by paying other claims arising out of the incident. On appeal, the Third District reversed concluding that coverage or restrictions on coverage cannot be extended by the doctrine of waiver and that United Auto had shown that its policy excluded coverage for the named insured or any relative while occupying a motor vehicle owned by the named insured but not listed under the policy which was the circumstance that applied in this case.

State Farm Mutual Automobile Insurance Company v. Nob Hill Family Chiropractic, 328 So. 3d 1 (Fla. 2021)

In this PIP case, State Farm retained both an accident reconstructionist and a causation expert to testify that the forces from the insured's accident were insufficient to cause injury. The trial court granted Plaintiffs' Motion for a *Daubert* hearing and then conducted a two-day hearing involving the biomedical engineer and the medical doctor. The Plaintiff argued that the doctor's causation analysis was "semi-junk science" and asserted that the doctor was unfamiliar with several significant variables which would have impacted the force applied to the insured. Counsel argued that the doctor never physically examined the insured and had an

opinion contrary to other doctors. The trial court concluded the hearing without making an oral ruling. Two months later, the trial court entered an order granting the *Daubert* challenge, finding that the insurer had met its prima facia burden to show that the doctor had minimal qualifications, but also finding that the doctor's data was insufficient, and his methodology was unreliable. The trial court made no factual findings that would support those conclusions. As to the insurance company's other expert, the trial court ordered State Farm to provide more complete and adequate responses to Interrogatories and awarded $1,000 in sanctions to the Plaintiff. When State Farm moved for reconsideration, the Plaintiff contended that the insurance company had not provided compliant responses due to inconsistencies and discrepancies. State Farm argued that, despite the discrepancies, the total amount that the insurance company had paid the physician/expert was $1,300,000 over the defined four-year period. The court found that there were deliberate violations of its orders, that Plaintiff suffered absolute prejudice in its ability to prepare a cross-examination of the expert, and that the prejudice was only cured by a continuance of the case that had been going on for over a decade. The court discussed the factors contained in *Kozel*, stating that they militated towards striking the doctor due to willful, deliberate, and contumacious disobedience. The Fourth District reversed both rulings. First it found that the trial court must make specific factual findings on the record sufficient for an appellate court to review a conclusion about whether testimony was scientifically reliable and factually relevant. In the absence of such findings, the court stated that Appellate Courts are not well-suited to exercise discretion reserved to trial courts in *Daubert* proceedings. Because the trial court here merely tracked the language of the relevant *Daubert* statute, §90.702, and only found factually that the doctor was essentially testifying as to the Plaintiff's medical condition without having ever examined the insured, the trial court concluded that the testimony was not reliable or trustworthy. The court also found that the Plaintiff failed to make a showing of willful failure of the Defendant to comply or to demonstrate any extensive prejudice with the withholding of the discovery and/or discrepancies. With respect to the prejudice, the court said that it was notable that each time the insurance company filed its unverified responses to the Interrogatories, they were identical to the later filed verified responses and further found it was significant that the insurance company was willing to stipulate to the $1,300,000 payment amount for the period, despite the discrepancies. The court concluded that striking the insurance company's remaining expert witness was neither an appropriate sanction nor commensurate with the offense and therefore reversed.

Central Florida Medical & Chiropractic Center v. Progressive American Insurance Company, 328 So. 3d 1111 (Fla. 5th DCA 2021)

Central Florida Medical (CFM) filed a Complaint against Progressive in County Court alleging that Progressive refused to pay CFM for medical services rendered to its insured following a motor vehicle accident. Progressive took the position that the insured failed to comply with Florida Statute §627.736(1)(a) which requires medical treatment be sought within 14 days of a motor vehicle accident. Progressive moved for Summary Judgment and approximately one month later sent CFM a Proposal for Settlement incorporating all provisions set forth under Florida Rule of Civil Procedure 1.442 and Florida Statute §768.79. CFM moved to strike the Proposal asserting that the case was filed pursuant to the Florida Small Claims Rules and that Rule 1.442 was not invoked pursuant to Small Claims Rule 7.020(c). The trial court ultimately granted Progressive's Motion for Summary Judgment. The trial court then awarded Progressive its fees and costs pursuant to the Proposal for Settlement. The Fifth District affirmed finding that Progressive was not required to specifically invoke Rule of Civil Procedure 1.442 in order for its Proposal for Settlement to be enforceable. The Rule unambiguously states that it applies to all Proposals for Settlement authorized by Florida law and the law is clear that Proposals for Settlement are authorized in PIP cases filed in small claims court.

State Farm Mutual Automobile Insurance Company v. Hollywood Diagnostic Center, Inc., 329 So. 3d 152 (Fla. 4th DCA 2021)

The Fourth District ruled that the trial court erred in granting summary judgment in favor of Hollywood Diagnostic with regard to the issue of the reasonableness of its charges. Specifically, it noted that the Affidavit and deposition testimony of the Center's owner were conclusory and self-serving and insufficient to support summary judgment because the owner did not have actual knowledge of reasonable prices. The Appellate Court also held that the trial court improperly struck the Affidavit of State Farm's expert coding witness who based her opinion on her experience of helping medical billing staffs establish fees, a review of thousands of CMS claim forms, experience with Medicare schedules, market investigation of benefit plans and a review of explanation of benefit forms. The Appellate Court also held that the trial court should not have entered summary judgment where there were competing expert Affidavits regarding the necessity and relatedness of medical care.

Precision Diagnostic, Inc. v. Progressive American Insurance Company, 330 So. 3d 32 (Fla. 4th DCA 2021)

The Fourth District held that the trial court erred by concluding that a fixed interest rate applied to an overdue insurance benefit payment due under a PIP policy. As they noted, the plain language of the relevant statutes required that the interest rate begin at the rate present for the quarter in which the payment became overdue, followed by an annual adjustment on January 1 of each year until payment is made.

Progressive Select Insurance Company v. Faderani, 330 So. 3d 928 (Fla. 4th DCA 2021)

Because the insured had exhausted his PIP benefits prior to the filing of suit, Progressive was not liable to Dr. Faderani for payment of the subject claim.

State Farm Mutual Automobile Insurance Company v. Palmetto Lakes Therapy & Rehabilitation, 330 So. 3d 951 (Fla. 4th DCA 2021)

In a lawsuit regarding the reasonableness of charges, the trial court struck the expert affidavit submitted by State Farm based upon one paragraph that the court found to be an opinion on a question of law. The Fourth District reversed Summary Judgment entered in favor of the clinic finding that it was not appropriate where a review of the rest of the affidavit showed that the expert considered multiple sources and explained the relevance of each to his analysis about the unreasonableness of the charges submitted by the clinic.

United Automobile Insurance Company v. Isot Medical Center Corp., 46 FLWD 2408 (Fla. 3d DCA 11/10/21)

Rodriguez was an insured of United Automobile and was injured in an accident. Thereafter, he sought treatment at Isot. Isot filed suit against United Automobile for breach of contract to recover benefits owed for medical services rendered. Summary Judgment was eventually entered in favor of Isot. The Third District affirmed and held that a claim for set-off in an insurance contract case must be raised by the insurance company as an affirmative defense. Because United Automobile did not assert the set-off as an affirmative defense and because no

evidence regarding the disputed benefits was presented to the finder of fact, the trial court appropriately denied set-off.

United Automobile Insurance Company v. Presgar Imaging of CMI South, LC, 46 FLWD 2466 (Fla. 3d DCA 11/17/21)

The trial court entered a directed verdict in favor of the medical provider based upon a finding that United Automobile's corporate representative "stipulated" in her deposition that the charges billed were related and medically necessary. The Third District reviewed and found that the testimony was not a clear and unambiguous statement that United Auto did not contest that the charges were related and medically necessary such that it constituted an enforceable stipulation and was properly viewed instead as impeachment testimony. Because the trial court improperly considered this deposition testimony and because Presgar did not present any evidence that the charges were medically necessary or related, United Automobile's Motion for Directed Verdict should have been granted and the Third District reversed with directions to enter judgment for the insurance company.

MRI Associates of Tampa v. State Farm Mutual Automobile Insurance Company, 46 FLWS 379 (Fla. 12/9/21)

In a unanimous decision, the Florida Supreme Court concluded that State Farm was within its right to use the statutory factors set forth under Florida Statute §627.736(5)(a) to determine the reasonableness of charges, along with the schedule of maximum charges that could be used to limit reimbursement and provisions related to the application of the schedule. Regardless of what might have appeared to be a "hyprid payment" methodology, the court ruled that State Farm could elect the limitations of the scheduled maximum charges.

Settlement agreement

Star Casualty Insurance Company v. Gables Insurance Recovery, 326 So. 3d 813 (Fla. 3d DCA 2021)

Portal was injured in an automobile accident and sought medical treatment from Finlay Diagnostic Center and Aesculapius Medical. Portal assigned his PIP benefits under his policy with Star Casualty to these providers, each of whom later

assigned their rights to Gables Insurance Recovery, Inc. Subsequently, Gables Insurance filed two separate lawsuits against Star Casualty for breach of contract based upon improper calculation of fee structure rates. Star Casualty confessed judgment in the Aesculapius case and the parties later entered into a settlement agreement. Following this settlement, the litigation involving Finlay Diagnostic continued for two years. Star Casualty then filed a Motion to Enforce the earlier settlement agreement asserting it had settled "all claims arising out of Portal's motor vehicle accident" including the claims raised in the Finlay Diagnostic litigation. Gables Insurance moved for sanctions and argued that the earlier settlement was solely for attorney's fees and costs related to the Aesculapius litigation and had nothing to do with the Finlay Diagnostic litigation.

The trial court conducted a non-evidentiary hearing at which time Star Casualty argued that the settlement agreement unambiguously encompassed both pending lawsuits and urged the trial court not to consider any parol evidence. Gables Insurance agreed that the court need not resort to parol evidence because there was no evidence of a "meeting of the minds" to settle the Finlay Diagnostic litigation. Alternatively, it argued that if the material terms of the agreement were ambiguous, the court could consider parol evidence in adjudicating the Motion to Enforce the settlement. Following argument by counsel, the trial court denied Star Casualty's Motion to Enforce the Settlement Agreement. Star Casualty then stipulated to a final judgment against it reserving its right to appeal the denial of its Motion to Enforce the Settlement.

On appeal, the Third District found that the language in the agreement contained a latent ambiguity such that it was necessary for the trial court to conduct an evidentiary hearing and consider parol evidence to determine the intent of the parties to the underlying settlement agreement.