

IN THE SUPREME COURT OF FLORIDA

CASE NO.: SC15-2298

L.T. CASE NO.: 4D14-0287

ALLSTATE INSURANCE COMPANY

Petitioner,

v.

ORTHOPEDIC SPECIALISTS a/a/o Kelli Serridge,

Respondent.

On Review from the District Court of Appeal, Fourth District, State of Florida

PETITIONER'S NOTICE OF SUPPLEMENTAL AUTHORITY

Pursuant to Florida Rule of Appellate Procedure 9.225, Petitioner submits as supplemental authority the attached Appellants' Opposition to Motion for Rehearing and/or Rehearing En Banc filed in *Allstate Indemnity Company v. Markley Chiropractic & Acupuncture, LLC as assignee of Illene Chavez*, Case No. 2D14-3818 and *Allstate Insurance Company v. Diagnostic Imaging Consultants of St. Petersburg, P.A., as assignee of Yosley Gonzalez*, Case No. 2D14-6058. This explains why Respondents' arguments concerning the New Second DCA Decision in their Sur-Reply Brief are incorrect.

RECEIVED, 05/13/2016 03:08:37 PM, Clerk, Supreme Court

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was sent
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**IN THE DISTRICT COURT OF APPEAL, STATE OF FLORIDA
SECOND DISTRICT**

**ALLSTATE INDEMNITY
COMPANY,**

Appellant,

vs.

CASE NO.: 2D14-3818

**MARKLEY CHIROPRACTIC &
ACUPUNCTURE, LLC,** as assignee of
Ilene Chavez,

Appellee.
_____ /

ALLSTATE INSURANCE COMPANY,

Appellant,

vs.

CASE NO.: 2D14-6058

**DIAGNOSTIC IMAGING
CONSULTANTS OF ST.
PETERSBURG, P.A.,** as
assignee of Yosley Gonzalez,

Appellee.
_____ /

**APPELLANTS' OPPOSITION TO MOTION FOR
REHEARING AND/OR REHEARING EN BANC**

Appellants, ALLSTATE INDEMNITY COMPANY and ALLSTATE INSURANCE COMPANY (hereinafter collectively "Allstate"), pursuant to Fla. R. App. P. 9.330, hereby responds to Appellees' MARKLEY CHIROPRACTIC &

ACUPUNCTURE, LLC, and DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, P.A., (hereinafter collectively “Appellees”)) Motion for Rehearing and/or Rehearing En Banc as follows:

Introduction

The issue decided in this case—the sufficiency of Allstate’s policy language giving notice of its election to apply authorized PIP reimbursement limitations—has now been decided by three District Courts of Appeal. In *Allstate Fire & Cas. Ins. Co. v. Stand-Up MRI of Tallahassee, P.A.*, No. 1D14-1213, 2015 WL 1223701 (Fla. 1st DCA Mar. 18, 2015), *pet. pending*, No. SC15-962 (“*Stand-Up*”), a unanimous panel of the First DCA held that Allstate’s language was sufficient. In *Orthopedic Specialists a/a/o Serridge v. Allstate Insurance Co.*, 177 So. 3d 19 (Fla. 4th DCA 2015) (“*Serridge*”) *review granted*, No. SC15-2298, a divided panel of the Fourth DCA held that Allstate’s language was not sufficient, and certified conflict with *Stand-Up*. In the instant case, a unanimous panel of this Court agreed with *Stand-Up*, upholding Allstate’s language, and certified conflict with *Serridge*.

The briefing in the Supreme Court in *Serridge* was completed April 25, 2016. Simply put, rehearing by this Court is not only unwarranted, as discussed *infra*, but is unnecessary as the question at issue will soon be decided by the Supreme Court in *Serridge*. Moreover, conflict with *Serridge* has been certified by this Court, and Appellees have recourse to file their petition with the Supreme Court on that basis,

which likely will pend, like *Stand-Up*, until *Serridge* is decided.

The Motion for Rehearing is Improper and Should Be Denied.

Florida Rule of Appellate Procedure 9.330(1) states that a motion for rehearing shall “state with particularity the points of law or fact in the court’s decision that, in the opinion of the movant, the court has overlooked or misapprehended in its decision.”

Thus rule has been interpreted to mean that “[a] motion for rehearing shall not reargue the merits of the court’s order.” *Jacobs v. Wainright*, 450 So. 2d 200, 202 (Fla. 1984).

Certainly it is not the function of a petition for rehearing to furnish a medium through which counsel may advise the court that they disagree with its conclusion, to reargue matters already discussed in briefs and oral argument and necessarily considered by the court, or to request the court to change its mind as to a matter which has already received the careful attention of the judges, or to further delay the termination of litigation.

State ex rel. Jaytex Realty Co. v. Green, 105 So. 2d 817, 818-19 (Fla. 1st DCA 1958); *see also Ayala v. Gonzalez*, 984 So. 2d 523, 526 (Fla. 5th DCA 2008) (reiterating the court’s view that the privilege to seek rehearing is not “an open invitation for an unhappy litigant or attorney to reargue the same points previously presented, or to discuss the bottomless depth of the displeasure that one might feel . . . as a result of having unsuccessfully sought appellate relief.”).

Unifirst Corp. v. City of Jacksonville, 42 So.3d 247, 248 (Fla. 1st DCA 2010). “[T]he filing of Rule 9.330 motions should be done under very limited circumstances; it is

the exception to the norm.” *Lawyers Title Insurance Corporation v. Reitzes*, 631 So.2d 1100, 1101 (Fla. 4th DCA 1993). Motions for rehearing which reargue points raised in the briefing and argument of the case are a “flagrant violation” of the motion for rehearing rule. *Parker v. Baker*, 499 So. 2d 843, 847 (Fla. 2d DCA 1986). They are not to be used as a vehicle to reargue the merits of the court’s decision. *Whipple v. State*, 431 So. 2d 1011, 1014 (Fla. 2d DCA 1983).

In the Motion for Rehearing, Appellees repeat the same arguments they made in their briefing and at oral argument. The central theme of their Motion for Rehearing is a purported “incontrovertible error”—this Court’s recognition that the only fee schedule limitations authorized by the No-Fault Statute appear in subsection (5)(a)2. (Motion at 7.) Appellees argue this is in error because “Allstate’s endorsement must be read as referring to the fee schedules in both subsections (5)(a)1 and (5)(a)2.” (*Id.* (emphasis in original).)

This is the same argument Appellees already briefed and argued. *See, e.g.:*

- Markley Answer Brief, p. 28 (“[Allstate’s] language does not clearly and unambiguously elect the Medicare Fee Schedule Method of Section 627.736(5)(a)2-5, because it also allows possible application of all other provisions of the PIP statute, including the Reasonable Amount Method of Section 627.736(5)(a)1 and the different ‘federal and state medical fee schedules applicable to automobile and other insurance coverages’ referenced therein”)
- Markley Answer Brief, p. 32 (“Because the Reasonable Amount Method references ‘federal and state medical fee schedules applicable to automobile and other insurance coverages’ in Section 627.736(5)(a)1, an insured patient or his health care provider has no way of knowing whether the Insurance Company has elected to limit its reimbursement specifically

to the different ‘Medicare’ fee schedules specifically referenced in Section 627.736(5)(a)2-5.”)

- Diagnostic Imaging Answer Brief, p. 21 (“The ‘all fee schedules’ provision might be referring to the non-Medicare fee schedules described in Section 627.736(5)(a)1, or the Medicare fee schedules specifically identified in Section 627.736(5)(a)2.a-f, or both.”)¹
- Diagnostic Imaging Answer Brief, p. 36 (“Because the Reasonable Amount Method references non-Medicare ‘federal and state medical fee schedules applicable to automobile and other insurance coverages’ in Section 627.736(5)(a)1, an insured patient or his health care provider has no way of knowing whether the Insurance Company has elected to limit its reimbursement specifically to the different “Medicare” fee schedules specifically referenced in Section 627.736(5)(a)2-5.”).

That argument was squarely rejected by this Court, noting that there are no other fee schedule payment limitations. 2016 WL 1238533, * 3.

As Allstate previously explained, Allstate’s language elects authorized limitations on amounts payable. Only Subsection 5(a)2. is a limitation on benefit

¹ Appellees’ suggestion that Allstate’s language is somehow inadequate because the words “fee schedule” do not appear in §627.736(5)(a)2.a through f (Motion at 12) is incorrect and ludicrous. First, §627.736(5)(a)3. actually explains that the references in Subsection (5)(a)2. are to **fee schedules**: “For purposes of subparagraph 2, the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect at the time the services, supplies, or care were rendered....” Moreover, as originally enacted, §627.736(5)(a)2.f actually did include the words “fee schedule.” *See* Laws 2007, c. 2007-324, § 20, eff. Jan. 1, 2008 (“200 percent of the applicable Medicare Part B **fee schedule**”) (emphasis added). A subsequent amendment to more specifically identify the applicable fee schedule changed that language. *See* Laws 2008, c. 2008-220, § 22, eff. July 1, 2008 (“200 percent of the allowable amount under the participating physicians schedule of Medicare Part B”). And, as Appellees concede, the references to “Medicare” in §627.736(5)(a)2.a. through f. do refer to fee schedules. (Motion at 12 (“allude to certain ‘Medicare’ reimbursement rates, which upon independent investigation, would be identified in a Medicare fee schedule”).

amounts payable. Subsection (5)(a)1. does not authorize an insurer to limit payments. Instead it is actually a restriction on health care providers.² *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*, 141 So. 3d 147, 153 (Fla. 2013) (“*Virtual IIP*”) (pre-2008 PIP amendments were “designed to regulate the amount providers could charge” while the 2008 amendment “permit[s] insurers to limit reimbursement”). “[W]hen read in conjunction with the actual applicable statute, it is clear that the only relevant limitation with respect to determining reasonable PIP coverage for medical expenses are the fee schedules at issue.” *S. Fla. Wellness, Inc. v. Allstate Ins. Co.*, 89 F. Supp.3d 1338, 1341 (S.D. Fla. 2015) (rejecting contention that Subsection 5(a)1. is a limitation on reimbursement because it “directs **providers**, not insurers, to charge reasonable rates”) (emphasis in original).

Appellees repeat their misguided assertion (Motion at 16, n.12) that “[t]he PIP statute includes many other limitations,” incorrectly referring to the statute’s coverage limits: \$10,000 in benefits; 80% of reasonable expenses; 60% of lost wages; and \$5,000 of death benefits. These statutory provisions are not “limitations” on benefit payments. Rather, they are the PIP coverage mandates set forth in § 627.736 (1)(a) through (c). Because Allstate’s language expressly refers to

² It is ludicrous to suggest that Subsection (5)(a)1. contains fee schedule **limitations** merely because it uses the words “fee schedules.” (Motion at 6). Subsection (5)(a)1. does not authorize insurers to apply any payment **limitations**, in the form of fee schedules or otherwise.

“limitations” to be applied to “amounts payable,” the other “limitations” Appellees refer to are not referenced. Moreover, they clearly do not conflict with an insurer’s election to limit medical expense reimbursement to the fee schedules set forth in Subsection (5)(a)2.

In the guise of supporting their assertion that this Court made an “incontrovertible error,” Appellees simply repeat their other arguments already made in the briefing and at argument. Those arguments were previously made and refuted:

- There is no ambiguity caused because Allstate’s policy both refers to the required PIP coverage mandate to pay 80% of reasonable medical expenses and also elects to use authorized PIP payment limitations. *Virtual III* conclusively established that coverage of reasonable expenses and use of authorized payment limitations are **not** mutually exclusive options. It rephrased the certified question at issue to expressly reject the idea that the issue was whether an insurer can limit benefits based on authorized limitations “rather than” paying reasonable medical expenses. *Virtual III*, 141 So. 3d at 150, n.3. Appellees ignore the rephrasing and the clarifications it represents.³

³ The Supreme Court rephrases certified questions “[t]o clarify the issue presented,” *State Farm Mut. Auto. Ins. Co. v. Roach*, 945 So. 2d 1160, 1162 (Fla. 2006), “to conform them more properly to the true issue under review,” *Gracey v. Eaker*, 837

- Appellees complain that this Court’s acknowledgment that “simple notice” is incorrect because it does not “clearly and unambiguously” elect the authorized payment limitations, citing references to those words in *Virtual III*. In fact, the words “clearly and unambiguously” appear exactly twice in the *Virtual III* opinion, referring to the general requirement that policy language be “clear and unambiguous.” Those references create no greater duty than an obligation that Allstate’s notice be clear and unambiguous, and do not alter the fact that “simple notice” is not inconsistent with clear and unambiguous. *Stand-Up MRI*, 2015 WL 1223701 at *2 (“*Virtual Imaging* requires no other magic words from Allstate’s policy and its simple notice requirement is satisfied by Allstate’s language”).

Appellees attempt to suggest that Allstate’s language is “no better (if not worse) than the Geico policy language that was invalidated in *Virtual Imaging*.” (Motion at 14.) However, *Virtual Imaging* did not invalidate any Geico policy language. Geico’s policy had no language giving notice of an election to use the authorized reimbursement limitations. Geico argued that “it was permitted to calculate reimbursements in accordance with the Medicare fee schedules because

So. 2d 348, 351 n.1 (Fla. 2002), “to more accurately reflect the issue presented,” *State v. Merricks*, 831 So. 2d 156, 158 (Fla. 2002), or to “emphasize the significance” of a certain concept, *Tiara Condo. Ass’n, Inc. v. Marsh & McLennan Cos.*, 110 So. 3d 399, 412 (Fla. 2013) (Canady, J., dissenting).

the 2008 amendments were incorporated into its policy.” 141 So. 3d at 158. The Supreme Court held that it was the lack of language giving notice that prohibited Geico’s use of those limitations.

Appellees’ motion for rehearing is simply their disagreement with this Court’s ruling. They do not identify anything this Court overlooked or misapprehended. Accordingly, rehearing should be denied.

Rehearing *En Banc* Should Be Denied

“The principal purpose served by en banc consideration is consistency in the court's decisions. The court may also proceed en banc on its own initiative on matters considered of exceptional importance.” 2nd DCA Internal Operating Procedures, Rule 6.9 (A) (2005). It is well-settled that the District Courts of Appeal will not grant an *en banc* rehearing on the basis of an alleged conflict with another opinion where the facts are not similar enough to require that both cases be decided in the same manner to maintain uniformity in the Court’s decisions. *See, e.g., Russo v. State*, 814 So. 2d 463, 464 (Fla. 4th DCA 2001).

Appellees do not even attempt to show that this Court’s Opinion creates a conflict with other 2nd DCA decisions. This action presented a case of first impression to this Court, and as such does not warrant rehearing *en banc* to resolve any conflict.

Appellees also do not even attempt to show that this case is of exceptional importance. They assert there is “importance” because the application of the limitations authorized by the legislature purportedly resulted in “underpayments of millions of dollars to health care providers” and payment of “‘minimum’ level of PIP benefits.”⁴ (Motion at 16, 17.) However, there is no minimizing of PIP benefits for insureds.

Fee schedule limitations do not minimize or reduce PIP benefits in any way. Insureds are guaranteed \$10,000 in PIP benefits which are not reduced by applying fee schedules. Applying fee schedule limitations only reduces the amount providers receive; insureds still get \$10,000 to pay for services.

⁴ Appellees erroneously cite to this Court’s earlier decision in *Nationwide Mut. Fire Ins. Co. v. AFO Imaging, Inc.*, 71 So.3d 134 (Fla. 2d DCA 2011), as characterizing Medicare fee schedules as “‘utilized in computing the minimum amount’ of PIP benefits.” This truncated quotation from *AFO Imaging* is disingenuous and misleading. This Court actually referred to “‘the participating physicians schedule of Medicare Part B’ as the operative fee schedule to be utilized in computing the minimum amount **the Insurance Companies were statutorily allowed to remit.**” 71 So.3d at 137 (emphasis added). This Court did not refer to any minimization of PIP benefits due to fee schedules or otherwise indicate, that the fee schedules represent a minimum “level” of **benefits**. In *Virtual III*, the Florida Supreme Court repeatedly notes that the PIP coverage mandate is for “reasonable expenses” and the Subsection (5)(a)2. fee schedules are simply a method to calculate “reasonable expenses” – indeed, in the instant case, this Court itself noted that the Legislature has “predetermined” reasonable expenses through use of the fee schedules. 2016 WL 1238533, * 3. Nowhere in the PIP Statute nor in *Virtual III* is there ever a delineation of different “levels” of **benefits**.

Thus, the “importance” Appellees ascribe to this issue is really their desire to maximize the amounts they can charge for services. The “underpayment” they claim is simply the result of the legislature’s policy decision to “regulate the amount providers could charge PIP insurers and policyholders for the medically necessary services PIP insurers are required to reimburse.” *Virtual III*, 141 So. 3d at 153. Appellees’ self-interest in higher rates for medical services does not serve the public good. “Providers...look to get paid as much as possible, but that does not inure to the insured’s benefit. The less costly the services provided, the more services the insured can receive.” *Serridge*, 177 So. 3d at 30 (May, J., dissenting). Requiring insurers to pay higher rates to medical providers is actually detrimental to insureds, whose coverage and benefits are maximized by limiting amounts payable to providers. *See also Virtual Imaging Services, Inc.*, 90 So. 3d 321, 327 (Fla. 3d DCA 2012) (“*Virtual II*”), *approved*, 141 So. 3d 147 (Fla. 2013) (“[I]nterpreting PIP insurance policies in favor of insureds actually requires reading the policies to cover the *lowest* amount possible.”) (Rothenberg, J., concurring) (emphasis in original).

This Court has already reviewed and answered the certified question of great public importance here. And, as previously noted, the same issue is fully briefed and pending before the Supreme Court. Appellees identify no reason why additional or heightened scrutiny of that question by this Court is warranted or necessary, except for their disagreement with this Court’s conclusion.

WHEREFORE Appellants, ALLSTATE INDEMNITY COMPANY and ALLSTATE INSURANCE COMPANY respectfully request that this Court deny Appellees' MARKLEY CHIROPRACTIC & ACUPUNCTURE, LLC, and DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, P.A., Motion for Rehearing and/or Rehearing En Banc.

Certificate of Service

I HEREBY CERTIFY that a copy of the foregoing has been sent by email to the following on April 29, 2016:

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