

IN THE DISTRICT COURT OF APPEAL OF THE STATE OF FLORIDA
THIRD DISTRICT

CASE NO.: 3D23-00797

L.T CASE NO: 20-9874 SP 25

ALLSTATE INDEMNITY COMPANY,

Appellant,

vs.

GADY ABRAMSON, D.C., P.A., a/a/o Zoila Crespo,

Appellee.

APPELLEE'S ANSWER BRIEF

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INTRODUCTION

Allstate Indemnity Company, defendant below, will be referred to as “Allstate” and Appellee Gady Abramson, D.C., P.A., (a/a/o Zoila Crespo), plaintiff below, will be referred to as “Plaintiff.” In this Brief, “R__” refers to the Corrected Record on Appeal. The Initial Brief will be referenced as “IB__.”

STANDARD OF REVIEW

“The standard of review is de novo, as the granting of a motion for summary judgment involves a question of law arising from undisputed facts. *Florida Bar v. Greene*, 926 So. 2d 1195, 1200 (Fla. 2006); *Sierra v. Shevin*, 767 So. 2d 524, 525 (Fla. 3d DCA 2000). Furthermore, [b]ecause the question presented requires this Court to interpret provisions of the Florida Motor Vehicle No-Fault Law – specifically, the PIP statute – as well as to interpret the insurance policy, our standard of review is de novo. *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*, 141 So. 3d 147, 152 (Fla. 2013).” *Mercury Indem. Co. of Am. v. Pan Am Diagnostic of Orlando*, 368 So. 3d 27, 30 (Fla. 3d DCA 2023).

Additionally, a trial court’s “ruling will be upheld if there is any theory or principle of law in the record which would support the ruling.” *Dade Cty. Sch. Bd. v. Radio Station WQBA*, 731 So. 2d 638, 644 (Fla. 1999). *See also, Ruff v. State*, 115 So. 3d 1023, 1025 n. 1 (Fla. 4th DCA 2013)(“The tipsy coachman doctrine permits an appellate court to affirm a trial court's decision on a ground other than that raised below, and argued on appeal, where there is support for the alternative theory or principle of law in the record before the trial court.”); *Duval Motors Co. v. Rogers*, 73 So. 3d 261, 264 n. 1 (Fla. 1st DCA 2011)(“[U]nder the tipsy coachman doctrine, if the result the trial court reached was correct for any reason reflected in the record, then it is subject to affirmance.”); *Ament v. One Las Olas, Ltd.*, 898 So. 2d 147, 149 n. 2 (Fla. 2^d DCA 2005)(“According to the ‘tipsy coachman’ doctrine, this court may affirm the judgment if it is legally correct, regardless of the trial court's reasoning.”).

STATEMENT OF THE CASE AND FACTS

Plaintiff submits the following Statement of the Case and Facts to identify areas in which it disagrees with Allstate and supply additional facts that Allstate omitted:

A. The Policy

Allstate issued an insurance policy providing \$10,000.00 in Personal Injury Protection (“PIP”) insurance benefits to Zoila Crespo. (R760-61, 773-79). The entire policy consists of Florida Auto Indemnity Policy form AIU109-1 and Florida Amendatory Endorsement form AIU687-5 (R783-826).

The operative policy language regarding reimbursement of PIP medical claims states:

1. Medical Expenses

Pursuant to the requirements of Section 627.736(1)(a) of the Florida Statutes: eighty percent of reasonable expenses; for medical, surgical, X-ray, dental, and rehabilitative services ... which are medically necessary...The methodology for determining the amount we will pay for such expenses shall, pursuant to the **fee schedule limitations** under Section 627.736(5)(a)1. of the Florida Statutes, **or any other limitations established by Section 627.736** of the Florida Statutes, or any other provisions of the Florida Motor Vehicle No Fault Law, as enacted, amended or otherwise continued in the law, be limited to eighty percent of the following schedule of maximum charges (**or any other fee schedule limitation** which may be enacted, amended or otherwise continued in the

law):

* * *

f. for all other **medical services**, supplies and care, 200 percent of the allowable amount under:

- (i) the participating physicians fee schedule of Medicare Part B, except as provided in subparagraphs (ii) and (iii) below.
- (ii) Medicare Part B, in the case of **services**, supplies and care provided by ambulatory surgical centers and clinical laboratories.
- (iii) The Durable Medical Equipment/Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

* * *

However, if such **services**, supplies or care is **not reimbursable under Medicare Part B**, as provided above, we will limit reimbursement to 80 percent of the maximum reimbursable allowance under worker's compensation, as determined under Section 440.13 of the Florida Statutes, and rules adopted thereunder which are in effect at the time such services, supplies or care is provided. *Services, supplies or care that is not reimbursable under Medicare or workers' compensation will not be reimbursed by us.*

* * *

Any amounts payable under this coverage shall be **subject to any and all limitations, authorized by Section 627.736** of the Florida Statutes, or any other provisions of the Florida Motor Vehicle No Fault Law, as enacted, amended or otherwise continued in the law, including, but not limited to, **all fee schedules**. (R817-18, 822) (emphasis added).

Allstate told its insured it would reimburse medically necessary **services**, supplies and care, pursuant to the statutory fee schedules under section 627.736 (5)(a)1., and that "any amounts payable under this coverage shall be subject to **any and all limitations, authorized**

by Section 627.736.” (R822). For the services at issue, the applicable fee schedule under section 627.736 (5)(a)1.f. for reimbursement is the Medicare Part B participating physicians fee schedule (“MPFS”). In applying the fee schedule payment methodology, the policy further states that “if such **services**, supplies or care is **not reimbursable under Medicare Part B**, as provided above, we will limit reimbursement to 80 percent of the maximum reimbursable allowance under worker’s compensation.”

Unremarkably, Allstate’s policy contains no statement that it will pay “reasonable expenses for *CPT codes*.” Nor does it state that “if a submitted *CPT code* is not reimbursable under Medicare Part B, we will limit reimbursement to 80 percent of the maximum reimbursable allowance under worker’s compensation.” To the contrary, the policy is devoid of any reference to reimbursing *CPT codes*, as Allstate’s policy (and PIP statute) reimburses **services**, supplies and care.

B. The PIP Claim

On May 30, 2019, during the policy period, Zoila Crespo sustained injuries in a motor vehicle accident. (R41, 54). Plaintiff treated Mrs. Crespo for her accident-related injuries from June 6, 2019 through September 13, 2019 under an assignment of benefits. (R42, 54). As part

of her treatment plan, Mrs. Crespo received Hydrobed therapy billed under CPT code 97039. Plaintiff's medical records included a detailed description of the service:

HydroBed therapy (97039) was applied to the cervical spine. \$30 The Dry heated Hydrobed therapy is so effective thanks to a combination of flotation, heat, and percussion Water is naturally buoyant. When you lie on the water-filled Dry Hydrobed mattress, water flows in to support your body, minimizing strain on muscles and weight-bearing joints. The timed wave pressure on your body increasing venuous and lymphatic flow. This allows healing processes to begin in the affected areas. Hydromassage also helps work out trigger points in your muscles, which often account for a lot of the pain and other problems that patients experience The heat causes your blood vessels to expand, which in turn increases your circulation. This increases the metabolism in the affected tissues. Heat also has a sedative effect and helps you to relax!

(R586). Plaintiff timely submitted its bills and accompanying medical records directly to Allstate for reimbursement. (R761).

In adjusting the claim, Allstate utilized the fee schedule payment methodology under section 627.736 (5)(a)1.a-f. (R761, 828-844, 880). Allstate reimbursed Plaintiff's services pursuant to the MPFS, with several exceptions. For CPT code 97039 (HydroBed therapy), Allstate reimbursed pursuant to Florida's workers' compensation fee schedule. (R764).

C. The Lawsuit

Plaintiff filed a single count breach of contract action against Allstate for its failure to properly pay Plaintiff for its medical services. (R41-52).¹ Plaintiff's Complaint asserted that "Defendant underpaid CPT code 97039 each time it was billed by paying an amount lower than the maximum allowable amount under the schedule of maximum charges." (R42). In response, Allstate filed its Answer and Affirmative Defenses. (R53-58).

Allstate asserted as its affirmative defense that it properly paid Plaintiff's bills in accordance with the subject policy, which states "the methodology for determining the amount we will pay for such expenses shall, pursuant to the fee schedule limitations under Section 627.736 (5)(a)1. of the Florida Statutes, **or any other limitations established by Section 627.736** of the Florida Statutes, **or any other provision of the Florida Motor Vehicle No-Fault Law**, as enacted, amended or otherwise continued in the law, be limited to eighty percent of the following schedule of maximum charges [provided for in section 627.736(5)(a)1.a.-f]." (R56). (emphasis added).

¹Plaintiff's amended Complaint filed on July 29, 2021 is the operative pleading, pursuant to Order entered on May 24, 2021. (R35-36).

On August 11, 2022, Plaintiff filed its Motion for Summary Judgment regarding underpayment of CPT code 97039. (R280-313). The Motion specified that the “pleadings, judicial notices, notices of filing summary judgment evidence, and answers to interrogatories and admissions... on file together with any affidavits” demonstrate Plaintiff is entitled to judgment. (R280).

Plaintiff’s position was simple. In determining reimbursement under section 627.736(5), the PIP statute focuses on the specific “service, supply, or care” provided, not the CPT code selected. Pursuant to section 627.736(5)(a)1.f., services are reimbursed at the allowable amount under Medicare Part B, and only if a service is *not reimbursable* under Medicare Part B, may an insurer default to reimbursing under workers’ compensation. Under the MPFS, CPT code 97039 is an allowed code with no “predetermined” value, as it is used to report procedures and services which do not have an assigned code. Medicare guidelines provide a specific payment methodology, which requires the Medicare Contractor² to determine reimbursement for CPT code 97039 on a case-by-case basis, by reviewing the specific service and

² Formally referred to as a Medicare Administrative Contractor (“MAC”). See 42 USC 1395kk-1.

supporting information provided and determining an appropriate value for the service provided. (R312-313,1447-1448).

In support of its Motion for Summary Judgment, Plaintiff filed a Request for Judicial Notice (“RJN”) of the Federal Register, Volume 70, No. 223, establishing CPT code 97039 is reimbursable under the MPFS and Medicare’s payment methodology for services submitted under CPT code 97039. (R1446-50). Plaintiff also requested judicial notice of the Medicare Contractor’s³ Local Coverage Determination (LCD) (L33413) and (L28992), providing descriptions of various therapy and rehabilitation services reimbursed under Medicare Part B, and the 2019 MPFS for CPT codes 97022. (R1451-1568).⁴ In addition, Plaintiff filed the affidavit of Dr. Gady Abramson, D.C. (R582-719). Dr. Abramson testified that he had personal knowledge of the facts contained in the affidavit and served as the corporate representative and records custodian for Plaintiff. (R583). Attached to Dr. Abramson’s affidavit were the patient’s medical records which provided Allstate with a detailed

³ Florida’s Medicare Administrative Contractor is First Coast Service Options. (R1452, 1501).

⁴ On March 3, 2023 the Court entered without hearing an Agreed Order granting both parties respective RJN without objection. (R1089-91).

description of the Hydrobed therapy service, and Medicare authorities showing CPT code 97039 is reimbursable based on the service provided and coding guidance for submitting services. (R679-719).⁵

Plaintiff also filed case law in support of its Motion for Summary Judgment and position that the PIP statute focuses on whether *services, supplies or care* are reimbursable under Medicare Part B, and not whether a *CPT code* is reimbursable at a specific dollar amount. (R314-45,1282-1345). These decisions included *Allstate Fire & Cas. Ins. Co. v. Perez ex rel. Jeffrey Tedder, M.D., P.A.*, 111 So. 3d 960 (Fla. 2nd DCA 2013) (statute focuses on whether services, supplies, or care is “reimbursable under Medicare Part B”; it does not require that CPT codes be recognized by Medicare for reimbursement purposes) (R315-19); *United Auto. Ins. Co. v. Lauderhill Med. Ctr. LLC*, 350 So. 3d 754 (Fla. 4th DCA 2022), *rev den. United v. Lauderhill*, 2023 WL 4558510 (Fla. 2023) (workers’ compensation schedule applies only if the services are not reimbursable under Medicare Part B. If a CPT code, such as 97039, has no set price but is still reimbursable under the Medicare fee

⁵Allstate failed to raise any contemporaneous objections concerning the admissibility of evidence at the April 18, 2023 hearing and presentation to the trial court. As a result, any issue regarding admissibility of evidence has not been preserved for appellate review. (IB. 13-14, 23, 53-54, 60, 62, 65, 68-69).

schedule, then the PIP statute would allow a reasonable amount up to 80% of 200% of the allowable amount) (R1284-88); and *United Auto. Ins. Co. v. Chironex Enterprises, Inc.*, 352 So. 3d 341 (Fla. 4th DCA 2022)(“statute places emphasis on the service provided. Focusing solely on the CPT code would be contrary to the dictates of the statute, where the relevant subsection does not even reference CPT codes”) (1289-92).

According to Plaintiff, Hydrobed therapy has no assigned code and is properly billed under CPT code 97039. The record evidence demonstrated that the therapeutic benefits and use of Hydrobed therapy⁶ in the course of treatment is comparable to that of Whirlpool therapy (CPT code 97022).⁷ The allowable amount under the MPFS in 2019 for Whirlpool therapy is \$37.62. (R584, R1089-91). Applying

⁶Hydrobed therapy is “a combination of flotation, heat, and percussion ... minimizing strain on muscles and weight-bearing joints ... increasing venous and lymphatic flow...work out trigger points...causes your blood vessels to expand ... increases circulation ... increases metabolism ... has a sedative effect and helps you to relax.” The goal is to reduce inflammation, muscle spasm and pain and improving function, increasing range of motion. (R586).

⁷Whirlpool therapy is a common form of hydrotherapy used to enhance the patient’s ability to perform therapeutic exercise and is indicated for patients with generalized weakness, functional limitation, requires joint stretching (joint range of motion), and when the therapeutic goal is to increase circulation. (R1463, 1513). Whirlpool is “useful in promoting relaxation (heat), or reductions of muscle spasms or spasticity (cold), and improving circulation and movement.” (R683, 1590).

Medicare's payment methodology for CPT code 97039, based on the description of the service and supporting documentation, a reasonable and appropriate value for Hydrobed therapy service is \$37.62. Allstate admitted to the relatedness and medical necessity of the service and filed no evidence showing the **service** was not reimbursable under Medicare Part B. Accordingly, in reimbursing Hydrobed therapy, Allstate erroneously defaulted to workers' compensation, rather than determining the proper allowable amount under Medicare Part B, resulting in an underpayment of CPT code 97039.

On February 2, 2023, Allstate filed its Response and Amended Motion for Summary Judgment as to CPT code 97039. (R721-56). Allstate argued that the reimbursement analysis centers on whether the submitted *CPT code* is reimbursable, which according to Allstate requires a *CPT code* to have a set price under the MPFS. To justify its position, Allstate puts forward a specious statutory argument that in amending the statute to include the phrase "as provided in this sub-subparagraph," the legislature intended that *services, supplies, or care* only be considered reimbursable under the MPFS if the *CPT code* utilized has a set value. According to Allstate, because CPT code 97039 has no set price or published RVUs, and instead priced by Medicare

Contractors, by determining a reasonable value based on the actual *service*, CPT code 97039 “is not reimbursable under Medicare Part B, as provided in” “the allowable amount under the participating physicians fee schedule of Medicare Part B.” (R 737). Confusingly, Allstate concedes CPT code 97039 is reimbursable under “*another aspect of Medicare Part B,*” but never clarifies which Medicare Part B fee schedule CPT code 97039 would instead be reimbursable under. (R744). Notably, Allstate does not argue the actual *service* at issue (Hydrobed therapy), was not reimbursable under Medicare Part B.

In support of its cross motion for summary judgment, Allstate filed the affidavit of its litigation adjuster, Christine Spisak. (R759-1055). The affidavit included a single conclusory statement that “Allstate reimbursed Plaintiff in full pursuant to the terms of the Policy and the No Fault Statute. Allstate adjusted Plaintiff’s bills utilizing the fee schedule payment methodology set forth within section 627.736(5)(a)1.” (R761). Despite acknowledging the medical records reflect the service provided was Hydrobed therapy, the adjuster testifies that “CPT code 97039, unlisted under Medicare Part B, was paid based on the reimbursement rates delineated in the Florida Workers Compensation Health Care Provider Reimbursement Manual.” (R764). Allstate also

requested judicial notice of excerpts from the *CPT Assistant*;⁸ five pages from the 2016 Florida Workers Compensation Health Care Provider Reimbursement Manual; a single line from the CMS Physician Fee Schedule Relative Value File for CPT code 97039;⁹ a PDF document from the RVU File; Local Coverage Determination (LCD) (L33413); and pages from the Federal Register, Volume 70, No. 223. (R1569- 1687).¹⁰

After narrowing the case down to the sole legal issue concerning proper reimbursement under section 627.736(5)(a)1.f. for Plaintiff's HydroBed therapy service, billed under CPT code 97039, both parties noticed their respective motions for summary judgment for hearing.

D. The Summary Judgment Hearing

On April 18, 2023, the trial court held a hearing on the parties' cross motions for summary judgment. (R1348-1431). Plaintiff maintained that reimbursement under section 627.736(5)(a)1. is based on the service provided, and not the CPT code. To determine the

⁸*CPT Assistant* Jan. 00:10, May 98:10, and Summer 95:5-10. (R1585-94).

⁹The RJN provides a website link to the complete RVU File, which includes 16,959 unique CPT codes and descriptions of services. (R1571).

¹⁰Plaintiff relied on the same *CPT Assistant* excerpts (R301-9, 680-88); Local Coverage Determination (LCD) L33413 (R1452-1500); and Fed. Reg., Vol. 70, No. 223. (R312-13, 691-92, 1447-48).

appropriate amount of reimbursement for medical services, the PIP statute authorizes insurers to use Medicare coding policies and payment methodologies. (R1396-98). Medicare's specific payment methodology for services submitted under CPT code 97039 is provided in the Federal Register (R1358-60):

We recognize that there may be services or procedures performed that have no specific CPT codes assigned. In these situations, it is appropriate to use one of the CPT codes designated for reporting unlisted procedures. These unlisted codes do not typically have RVUs assigned to them.

For services coded using these unlisted codes, the provider includes a description of the specific procedure(s) that was furnished. The contractor uses this information to determine an appropriate valuation. As explained in the August 8, 2005 [Physician Fee Schedule] proposed rule (70 FR 45788), currently there are two unlisted CPT codes with assigned RVUs, CPT 97039, Unlisted modality, and 97139 Unlisted therapeutic procedures.

To make the pricing methodology consistent with our policy for other unlisted services, and to more appropriately match payments with the actual resources expended to deliver the services provided, we proposed to have our contractors value CPT codes 97039 and 97139...

...While it is true having these codes priced by the contractors may result in some increase in administrative burden and impact the timeliness of payments, it will not necessarily result in lower payments. Our goal is to ensure appropriate payment for the actual services provided.

We are finalizing our proposal and our contractors will value CPT code 97039 and 97139. We are assigning a status indicator of "C" to these two CPT codes.

70 Fed. Reg. 70160-61. (R1447-48).

Plaintiff demonstrated that in applying Medicare's payment methodology for CPT code 97039 to the record evidence, including Dr. Abramson's affidavit, the medical records description of Hydrobed therapy, LCDs issued by Florida's MAC and coding authorities describing how whirlpool therapy is used and therapeutic benefits, an appropriate value for Hydrobed therapy under the MPFS is \$37.62. (R1353-58).¹¹

Allstate dismissed out of hand that Hydrobed therapy is reimbursable under the MPFS at \$37.62. Allstate argued that Plaintiff filed no evidence of a specific dollar amount for Hydrobed therapy under the MPFS or the amount a Medicare Contractor would have reimbursed for the service, despite failing to put forward another dollar amount that its believed *would* have been proper under the MPFS. (R1383-85). Instead, Allstate asserted it properly reimbursed *CPT code* 97039 under workers' compensation, without any determination that the *service* was not reimbursable under Medicare Part B.

The record evidence demonstrated that Hydrobed therapy is reimbursable under Medicare Part B. Allstate admitted the services were

¹¹ Allstate did not contest the admissibility of Plaintiff's evidence at the hearing, nor did it raise any contemporaneous objections to the trial court.

related and medical necessity and filed no evidence Hydrobed therapy is not a reimbursable service. (R1352, 1365-66, 1381). Allstate's affidavit concedes the service provided was Hydrobed therapy, but is notably silent on whether the service was reimbursable under Medicare Part B. Instead, the affidavit stated that "the unit of CPT code 97039, unlisted under Medicare Part B, was paid based on the reimbursement rates delineated in the Florida Worker's Compensation Manual." (R764). Considering the undisputed record, Allstate's deafening silence on the issue is telling.

As a result of its failure to address this issue, the trial court questioned Allstate on its position of whether the service was reimbursable under Medicare Part B:

COURT: Here's my one thing, Mr. Tano is that it says in this case from the Fourth, which I'm bound by, that the *Worker's Compensation schedule applies only if the services provided are not reimbursable under Medicare Part B*. So, to me that's like the crux of it. Is it reimbursable under Medicare Part B and *I think the answer to that is yes*. Do you disagree with that?

MR. TANO: It can be - yes and no. I acknowledge that you're bound by law to do it -

COURT: But I didn't see anything in your papers that said it was not reimbursable.

MR. TANO: We're *not arguing* that it is *not reimbursable under Medicare generally*...

COURT: So, I think the only question I'm allowed to ask at this time is whether the *service* is reimbursable under Medicare Part B. And *I haven't seen anything in your papers that says it, you know, it's not reimbursable.*

MR. TANO: *That's correct, Your Honor.*

(R1386-87, 1389-90) (emphasis added).

Allstate's admission to the trial court that the service is "reimbursable under Medicare generally" confirmed the record was undisputed that Hydrobed therapy is a reimbursable service. Moreover, it exemplifies the untenable nature of Allstate's argument that under section 627.736(5)(a)1.f., it was permitted to default reimbursing Hydrobed therapy under workers' compensation, based solely on *CPT code 97039* having no set price, notwithstanding its admission that the *service* was related, medically necessary, and reimbursable under Medicare.

On May 1, 2023, the trial court entered an Order granting Plaintiff's motion for summary judgment, denying Allstate's cross-motion, and entering Final Judgment for Plaintiff. (R1440-42). The trial court based its ruling on the undisputed facts, record evidence, Allstate's admissions, and the Fourth District's binding decision on the same legal issue in *Lauderhill Med.* Allstate did not move for rehearing. Allstate timely filed a Notice of Appeal. (R1432).

SUMMARY OF THE ARGUMENT

The exceedingly narrow issue presented in this appeal concerns reimbursement of services, supplies, and care under section 627.736(5)(a)1.f. Fla. Stat. The PIP statute's plain language provides that services are reimbursed at the allowable amount under Medicare Part B, and only if a service is *not reimbursable*, may an insurer default reimbursement to the workers' compensation schedule. Far from being novel, the courts have been consistent on this issue and the uniformity of decisions from the Second District in *Perez* and Fourth District in *Lauderhill* and *Chironex*, are dispositive in this case.

In its seminal decision in *Allstate v. Perez*, 111 So. 3d 960 (Fla. 2nd DCA 2013), the Second District considered this exact issue and concluded that the PIP statute "focuses on whether services, supplies, or care is "reimbursable under Medicare Part B"; it does not require that CPT codes be recognized by Medicare for reimbursement purposes." *Id.* at 963. The *Perez* court explained that while CPT codes assist in identifying services, "a CPT code alone does not dictate whether a service is reimbursable under the statute... it is the nature of the medical service that controls." *Id.*

The holding and statutory analysis in *Perez* were reaffirmed by the Fourth District in *United Auto. v. Lauderhill Medical*, 350 So. 3d 754 (Fla. 4th DCA 2022). In citing with approval to *Perez*, the Fourth District in *Lauderhill* held:

A key provision of section 627.736(5) is that “if such services, supplies, or care is *not reimbursable* under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers’ compensation, as determined under s. 440.13...”. Thus, the workers’ compensation schedule applies only if the services provided are not reimbursable under Medicare Part B. If a CPT code, such as 97039, has no set price but is still reimbursable under the Medicare fee schedule, then the PIP statute would allow a reasonable amount up to 80% of 200% of the allowable amount, instead of the workers’ compensation schedule.

Id. at 756-57. Only three weeks after *Lauderhill* was decided, the Fourth District issued another ruling in *United Auto. v. Chironex*, 352 So. 3d 341 (Fla. 4th DCA 2022).

In *Chironex*, the Fourth District reiterated that the relevant statutory provision, “if such services, supplies, or care is not reimbursable under Medicare Part B,” places the emphasis for reimbursement on the service provided. Resolving any dispute regarding its prior holding in *Lauderhill*, the Fourth District stating in no uncertain terms:

Focusing solely on the CPT code would be contrary to the dictates of the statute, where the relevant subsection does not even reference CPT codes. Just like *Lauderhill Medical*, “we are bound by the plain language of section 627.736(5)(a)(1)(f), which does not require a CPT code to be recognized by Medicare Part B if the services are otherwise covered and reimbursable under Medicare Part B.” *Id.* (quoting *Perez*, 111 So. 3d at 964) (emphasis omitted). We find that the focus of the last portion of subsection (5)(a)(1)(f), allowing an insurer to avoid reimbursement if the service is not covered under Medicare Part B and workers’ compensation, is also on the service provided.

Id. at 345. Simply put, when reimbursing services, supplies or care under section 627.736(5)(a)1., an insurer is prohibited from reimbursing under the workers’ compensation schedule, unless it first determines the *service* is not reimbursable under Medicare Part B.

The undisputed record evidence demonstrated that Hydrobed therapy, billed using CPT code 97039, was related, medically necessary, and a reimbursable service under Medicare Part B. Medicare uses a payment methodology for services submitted under CPT code 97039, that determines reimbursement by reviewing the specific service and supporting information provided and determining a reasonable value for the service.

Allstate overinflates Plaintiff’s burden in this case, insinuating the evidence must prove “exactly” how Medicare would reimburse the

service. Plaintiff met its burden of proof by applying Medicare's payment methodology and providing competent, substantial evidence that an appropriate value and allowable amount for the Hydrobed therapy under Medicare Part B is \$37.62, which is greater than the \$15.00 Allstate improperly allowed under workers' compensation.

Allstate on the other hand did not meet its burden of proving its affirmative defense of proper payment. Allstate's position was that it could determine reimbursement based *solely* on the CPT code utilized. Allstate argued that because CPT code 97039 has no set price, it is not reimbursable under the MPFS. According to Allstate, this allowed them to reimburse \$15.00 under worker's compensation, without having to determine if the service itself was reimbursable under Medicare.

In rejecting Allstate's position, the trial court correctly followed the uniformity of District Court decisions, which agree the plain language of the PIP statute focuses on whether a *service* is reimbursable and not a *CPT code*, as confirmed by *Perez*, *Lauderhill* and *Chironex*. Applying the correct law to the record evidence and undisputed facts, the trial court found, "based on the **undisputed evidence** in this case, Defendant's **admission** as to the **relatedness and medical necessity** of Plaintiff's services, **no evidence** being presented that **the services** at

issue **were not reimbursable under Medicare Part B**, and the binding decision in *Lauderhill*, Defendant improperly reimbursed CPT code 97039 at \$15.00 by defaulting to the Workers Compensation fee schedule, rather than reimbursing an “a reasonable amount up to 80% of 200% of the allowable amount” under the Medicare Part B PFS.” (R1441) (emphasis added).

Allstate bet the house on a tenuous statutory argument, and now has only one card left to play: dispute the sufficiency of evidence by muddying the water. Unfortunately for Allstate, the record is crystal clear. Plaintiff provided competent, substantial evidence of a reasonable and appropriate value for Hydrotherapy under the MPFS. Allstate *admitted* the services were related and medically necessary. Allstate filed *no evidence* disputing the service was reimbursable under Medicare Part B. Allstate *admitted* the service was reimbursable under Medicare “generally.” Allstate provided *no evidence* that another dollar amount would have instead been proper to reimburse Hydrobed therapy under the MPFS.

Allstate now attempts to tip the scales in its favor by raising unpreserved arguments concerning admissibility of evidence. At the hearing and presentation to the trial court, Allstate did not contest the

admissibility of Plaintiff's evidence, nor did it raise a contemporaneous objection to the trial court. As a result, any issue related to admissibility of evidence has not been preserved on appeal. *See Harrell v. State*, 894 So. 2d 935 (Fla. 2005) (in order to preserve an error for appellate review a party must make a timely, contemporaneous objection, state the legal ground for the objection, and obtain a ruling on that objection).

As this Court has previously held, "in reviewing a final judgment rendered from a non-jury trial, the trial court's findings of fact are clothed with a presumption of correctness. *Fito v. Attorney's Title Ins. Fund, Inc.*, 83 So.3d 755, 757-58 (Fla. 3d DCA 2011). We apply a clear error standard to the findings of fact, and a finding will not be disturbed unless it is totally unsupported by competent and substantial evidence, it is clearly against the weight of the evidence, or it was induced by an erroneous view of the law. *Id.*; *Holland v. Gross*, 89 So.2d 255, 258 (Fla. 1956)." *La Ley Sports Complex at City of Homestead, LLC v. City of Homestead*, 255 So. 3d 468, 469 (Fla. 3rd DCA 2018).

Under this framework, Allstate has failed to meet its heavy burden on appeal of demonstrating reversible error. The trial court's entry of final summary judgment for Plaintiff must therefore be affirmed.

ARGUMENT

I. ALLSTATE DID NOT PRESERVE ANY ARGUMENT RELATED TO ADMISSIBILITY OF EVIDENCE

In its Brief, Allstate attempts to bolster its anemic attack on the sufficiency of record evidence, by sprinkling in commentary directed towards the admissibility of Plaintiff's evidence. (IB13, 62, 68-69). Allstate also uses the phrase "admissible evidence" throughout its Brief. (IB14, 23, 53-54, 60). This is curious, considering the word "admissible" is notably absent from the eighty-three (83) pages of hearing transcript. (R1348-1431). Also absent from the transcript are any objections by Allstate to the admissibility of evidence. At the hearing, Allstate did not contest the admissibility of evidence relied upon by Plaintiff, nor did it raise any contemporaneous objections to the trial court.

Perhaps the most basic principle of preservation is that a party must make a contemporaneous objection in the trial court. *See Sunset Harbour Condo. Ass'n v. Robbins*, 914 So. 2d 925, 928 (Fla. 2005) ("In order to be preserved for further review by a higher court, an issue must be presented to the trial court and the specific legal argument or ground to be argued on appeal or review must be part of that presentation if it is to be considered preserved.") (quoting *Tillman v. State*, 471 So. 2d 32,

35 (Fla. 1985)); *Harrell v. State*, 894 So. 2d 935, 940 (Fla. 2005) (preservation requires a timely, contemporaneous objection; argument of legal grounds in support of the objection; and assertion of the exact argument on appeal).

Proper preservation of error for appellate review requires three components. First, the party must make a timely, contemporaneous objection at the time of the alleged error. *See Overton v. State*, 976 So.2d 536, 547 (Fla. 2007); *Harrell v. State*, 894 So.2d 935, 940 (Fla. 2005). “Second, the party must state a legal ground for that objection. Third, “[i]n order for an argument to be cognizable on appeal, it must be the specific contention asserted as legal ground for the objection, exception, or motion below.” *Harrell*, 894 So.2d at 940 (quoting *Steinhorst v. State*, 412 So.2d 332, 338 (Fla.1982)); *see also Sunset Harbour Condo. Ass’n v. Robbins*, 914 So.2d 925, 928 (Fla. 2005) (“In order to be preserved for further review by a higher court, an issue must be presented to the lower court and the specific legal argument or ground to be argued on appeal or review must be part of that presentation if it is to be considered preserved.” (quoting *Tillman v. State*, 471 So.2d 32, 35 (Fla.1985))).

While no “magic words” are required, the objection must be articulated with enough specificity to notify the trial judge of an error

and the opportunity to make a ruling. See *Williams v. State*, 414 So.2d 509, 511–12 (Fla.1982); *Castor v. State*, 365 So.2d 701, 703 (Fla.1978) (“[A]n objection must be sufficiently specific both to apprise the trial judge of the putative error and to preserve the issue for intelligent review on appeal.”). “The rule is well settled that an appellate court will not consider matters urged for reversal unless the lower court had been afforded a full and adequate opportunity to consider such contentions.” *Walker v. Hampton*, 235 So. 2d 325, 326 (Fla. 1st DCA 1970). This makes sense, because “the function of an appellate court [is] to review matters previously considered and ruled on by the lower court, not questions presented [on appeal] for the first time.” *City of Pensacola v. Kirby*, 47 So. 2d 533, 534 (Fla. 1950). Here, because Allstate did not object at the hearing, did not file a motion to strike, and did not obtain a ruling by the trial court, Allstate did not preserve any argument related to the admissibility of the record evidence.

Not only was this issue not preserved for appeal, it is also foreclosed from appellate review under the invited error doctrine. The doctrine prevents a party from inviting error, then attempting to make that error an issue on appeal. See *Norton v. State*, 709 So.2d 87 (Fla. 1997); *Terry v. State*, 668 So.2d 954, 962 (Fla. 1996). Applied here, the

doctrine prevents Allstate from raising an objection related to admissibility of evidence through a motion, then stay silent during the hearing and presentation to the trial court, and now attempt to make the admissibility of evidence an issue in this appeal.

Based on the entirety of record evidence before it, the trial court correctly found no genuine issue of material fact existed, entitling Plaintiff to final summary judgment.

II. THE FINAL JUDGMENT SHOULD BE AFFIRMED PURSUANT TO THE CLEAR AND UNAMBIGUOUS LANGUAGE OF § 627.736(5)(A)1.-5., FLA. STAT., AS CONFIRMED BY THE UNIFORMITY OF DECISIONS IN LAUDERHILL, CHIRONEX AND PEREZ.

The issue in this case concerns reimbursement of medically necessary “services supplies, or care,” under section 627.736(5)(a)1., Fla. Stat., and whether a service is “reimbursable” under Medicare Part B. On the question presented here—which ultimately turns on the interpretation of the PIP statute—this Court should join the well-reasoned decisions from the Second District in *Perez*, and Fourth District in *Lauderhill* and *Chironex*, concluding that the meaning of the governing text is clear beyond any doubt: Under the plain language of the statute, the ***nature of the medical service that controls, not the billed CPT code.***

Allstate attempts to overcomplicate the statutory analysis, by taking this Court through a labyrinth of convoluted arguments, unnecessary cannons, and fanciful legislative intent, that ends with an erroneous reading of the PIP statute. The law in Florida, however, is well established. When a statute is clear and unambiguous, “courts will not look behind the statute’s plain language for legislative intent or resort to rules of statutory construction to ascertain intent.” *Daniels v. Florida Dep’t of Health*, 898 So. 2d 61, 64 (Fla. 2005).

A. Reimbursement Under Section 627.736(5)(a)1. Focuses on Whether the Service is Reimbursable Under Medicare Part B, Not the CPT Code.

“The PIP statute sets forth a basic coverage mandate: every PIP insurer is required to—that is, the insurer “shall”—reimburse eighty percent of reasonable expenses for medically necessary services. This provision is the heart of the PIP statute's coverage requirements.” *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*, 141 So. 3d 147, 155 (Fla. 2013).

Through various amendments over the years, the PIP statute currently provides two reimbursement options for insurers to satisfy the reasonableness mandate: (1) the default “reasonable charge” methodology, which is a fact-specific analysis of whether a provider’s

charges for services are reasonable under the factors set forth in § 627.736(5)(a), Fla. Stat., or alternatively, (2) the permissive “fee schedule methodology,” which includes the schedule of maximum charges set forth in sections 627.736(5)(a)1.a.- f., Fla. Stat.

In this case, the applicable fee schedule is under section 627.736(5)(a)1.f., Fla. Stat., which reimburses services at 200% of Medicare Part B. The statute provides as follows:

1. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

f. For all other medical **services, supplies, and care**, 200 percent of the allowable amount under:

(I) The participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

However, if such **services, supplies, or care** is **not reimbursable under Medicare Part B**, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers’ compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. **Services, supplies, or care** that is **not reimbursable under Medicare** or workers’ compensation is not required to be reimbursed by the insurer.

§ 627.736(5), Fla. Stat. (2019) (emphasis added). “Provisions governing the application of the schedule of maximum charges are detailed in subsection (5)(a)2.-5.” *MRI Assocs. of Tampa, Inc. v. State Farm Mut. Auto. Ins. Co.*, 334 So. 3d 577, 580 (Fla. 2021). Relevant to the inquiry at hand, section 627.736(5)(a)3. also provides that:

subparagraph 1. does not prohibit an insurer from using the **Medicare coding policies and payment methodologies** of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to **determine the appropriate amount of reimbursement for medical services**, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

§ 627.736(5)(a)(3), Fla. Stat. (2019).

“When interpreting the PIP statute, like all other statutory provisions, a court is bound by the plain language meaning of the text and its provisions. *MRI Assoc.*, 334 So. 3d at 583. A court is to “presume that a legislature says in a statute what it means and means in a statute what it says there.” *Id.* We are required to give effect “to every word, phrase, sentence, and part of the statute if possible, and words in a statute should not be construed as mere surplusage.” *Am. Home Assur. Co. v. Plaza Materials Corp.*, 908 So. 2d 360, 366 (Fla. 2005). Finally, “a basic rule of statutory construction provides that the Legislature does not intend to enact useless provisions, and courts should avoid readings

that would render part of a statute meaningless.” *Id.* “[R]elated statutory provisions must be read together to achieve a consistent whole, and that [w]here possible, courts must give full effect to all statutory provisions and construe related statutory provisions in harmony with one another.” *Woodham v. Blue Cross & Blue Shield of Fla., Inc.*, 829 So. 2d 891, 898 (Fla. 2002).” *Lauderhill* at 756.

In its Brief, Allstate begs this Court to adopt its “fair reading” of section 627.736(5)(a)1., that based on amending the statute to include the phrase “as provided in this sub-subparagraph,” the legislature intended that “*services, supplies, or care*” only be considered reimbursable under the MPFS, if the *CPT code* utilized has a set value. While Allstate claims this is in harmony with statutes “plain and unambiguous” language, Allstate then proceeds to spend the next twenty-six (26) pages of its Brief trying to explain how its square interpretation somehow fits into the circle of statutory language.

To confirm Allstate is wrong, this Court need only take a single paragraph, by turning to “what Justice Thomas has described as the ‘one, cardinal canon [of construction] before all others’—that is, we ‘presume that a legislature says in a statute what it means and means

in a statute what it says there.” *MRI Assocs. v. State Farm, Id.* at 583 (Fla. 2021). The statute refers only to “services” being reimbursable, therefore it is the services that controls, not the CPT code. To be sure, the uniformity of District Court decisions demonstrates Allstate’s reliance on the CPT code, rather than service provided, is simply untenable.

In the seminal case of *Allstate v. Perez*,¹¹ 111 So. 3d 960 (Fla. 2nd DCA 2013), the Second District considered this exact issue and concluded that the PIP statute “focuses on whether services, supplies, or care is “reimbursable under Medicare Part B”; it does not require that CPT codes be recognized by Medicare for reimbursement purposes.” *Id.* at 963. The *Perez* court explained that while CPT codes assist in identifying services, “a CPT code alone does not dictate whether a service is reimbursable under the statute... it is the nature of the medical service that controls.” *Id.* As noted in *Perez*, services are “still covered by Medicare Part B if they are medically reasonable and necessary. It then follows that the services are “reimbursable under Medicare Part B” for purposes of section 627.736(5)(a)2.”¹² *Id.* at 963. Applied to the

¹² Currently section 627.736(5)(a)1.

undisputed facts here, as Hydrobed therapy was related, medically necessary, and reimbursable under Medicare Part B, under *Perez*, it was “reimbursable under Medicare Part B for purposes of section 627.736(5)(a)[1].” *Id.*

For more than a decade, the analysis and statutory interpretation in *Perez* has stood the test of time. Putting to bed any hope that Allstate could escape the application of the *Perez* decision based on the 2012 amendments, the Fourth District reaffirmed the holding of *Perez* in both its *Lauderhill* and *Chironex* decisions. In citing with approval to *Perez*, the Fourth District in *Lauderhill* held:

A key provision of section 627.736(5) is that “if such services, supplies, or care *is not reimbursable* under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers’ compensation, as determined under s. 440.13...”. Thus, the workers’ compensation schedule applies only if the services provided are not reimbursable under Medicare Part B. If a CPT code, such as 97039, has no set price but is still reimbursable under the Medicare fee schedule, then the PIP statute would allow a reasonable amount up to 80% of 200% of the allowable amount, instead of the workers’ compensation schedule.

Id. at 756-57. Three weeks later, the same court decided *Chironex*, and once again reaffirming the PIP statute places the emphasis for reimbursement on the *service* provided. *Id.* As explained by the Fourth

District in *Chironex*:

Focusing solely on the CPT code would be contrary to the dictates of the statute, where the relevant subsection does not even reference CPT codes. Just like *Lauderhill Medical*, “we are bound by the plain language of section 627.736(5)(a)(1)(f), which does not require a CPT code to be recognized by Medicare Part B if the services are otherwise covered and reimbursable under Medicare Part B.” *Id.* (quoting *Perez*, 111 So. 3d at 964). We find that the focus of the last portion of subsection (5)(a)(1)(f), allowing an insurer to avoid reimbursement if the service is not covered under Medicare Part B and workers’ compensation, is also on the service provided.

Id. at 345. Simply put, when reimbursing services, supplies or care under section 627.736(5)(a)1., an insurer is prohibited from reimbursing under the workers’ compensation schedule unless it first determines the *service* is not reimbursable under Medicare Part B.

As made clear in its Initial Brief, Allstate takes umbrage with the mere suggestion that it be required to look at the *actual service* provided when submitted using CPT code 97039. According to Allstate, unless it can immediately ascertain a set price for a CPT code, it is allowed to default reimbursing under worker’s compensation, without having to burden itself with checking what service was performed. Allstate is wrong for three reasons.

First, this position has been flatly rejected by the District Courts. In *Perez*, the Second District held:

[W]e understand the confusion that is likely caused when a provider uses a CPT code that, while still valid in the medical community, is no longer recognized by the current Medicare Part B schedule but the services are considered covered and therefore reimbursable under Medicare Part B. As in this case, the insurer would have to look beyond the CPT code to determine whether the services represented in the code are reimbursable under Medicare Part B. We understand that this complicates the reimbursement process under the PIP statute. Nonetheless, we are bound by the plain language of section 627.736(5)(a)(2)(f), which does not require a CPT code to be recognized by Medicare Part B if the services are otherwise covered and reimbursable under Medicare Part B.

Id. at 964. Following this pronouncement, the insurer in *Lauderhill* attempted to distinguish *Perez*, as it was decided under the prior version of the PIP statute, while the current version includes the additional language “as provided in this sub-subparagraph,” just as Allstate argues here. In rejecting the argument, the *Lauderhill* court found that:

The additional verbiage does not change our reliance on *Perez*. The amended version of the statute does not change the focus on whether the service is reimbursable under Medicare Part B. Nothing in the statutory version, effective at the time of the *Perez* case or the present case, added a requirement that CPT codes have a set value under a fee schedule under Medicare to be reimbursed. Had the legislature intended that those services have a corresponding and specific set reimbursement rate under Medicare or default to the workers’ compensation billing, it would have said so. This court is not empowered to impose an additional statutory requirement for reimbursement not written by the legislature.

Id. at 758.

Second, Allstate's reliance and sheer weight given to the newly added language "as provided in this sub-subparagraph," is hard to understand when viewed in proper context. According to Allstate, the addition of "as provided in this sub-subparagraph," is a game changer, as it *for the first time* modifies "the penultimate sentence" by pointing back to the MPFS. Allstate asserts this is because as "a change in the language of a prior statute presumably connotes a change in meaning." (IB43). Indeed, Allstate is correct that the statute's meaning did change, but not how Allstate thinks it did.

As noted, the 2012 amendments included the addition of several Medicare Part B fee schedules. However, rather than restrict coverage of reimbursable services, the amendment *broadened* the types of services reimbursable under Medicare Part B to include services performed by clinical laboratories, ambulatory surgical centers and for durable medical equipment. Logically, if section 627.736(5)(a)1.f. now ***for the first time*** contains three different Medicare Part B fee schedules, that were ***for the first time*** placed into sub-subparagraphs, then it is hardly surprising that the statute would also be amended to include "as provided in this sub-subparagraph" directly below these other amendments.

Moreover, under the prior version of the statute, section 627.736(5)(a)2.f. included only *one* Medicare Part B fee schedule, the participating physicians fee schedule. Accordingly, the statutory language directly below stating, “[h]owever, if such services, supplies, or care is not reimbursable under Medicare Part B,” could only be pointing to the *one* Medicare Part B fee schedule provided above: the participating physician fee schedule. In other words, Allstate’s entire premise that *for the first time* the “penultimate sentence” was modified to point to the participating physicians fee schedule, should be amended to accurately state: “*for the **second** time.*”

However, this was not the only substantive amendment which must be considered. Also included in the 2012 amendments was the addition of section 627.736(5)(a)3., which *for the first time* permitted the use of Medicare coding policies and payment methodologies by insurers, in determine the “*appropriate amount of reimbursement for medical services.*”

The Legislature “is presumed to know the judicial constructions of a law when enacting a new version of the law” and “is presumed to have adopted prior judicial construction of a law unless a contrary intent is expressed in the new version.” *Essex, Ins. Co. v. Zota*, 985 So. 3d 1036,

1043 (Fla. 2008); *Brandon v. Tampa Tribune*, 711 So. 2d 97, 100 (Fla. 1st DCA 1998). In permitting the use of Medicare coding policies and payment methodologies by insurers, the Legislature did indeed connote a change in meaning of the “allowable” amount under section 627.736(5)(a)1.f. As newly constructed, the statute does not obligate the insurer to pay what is listed on the participating physicians schedule of Medicare Part B; rather, the statute requires that the insurer pay what is ‘allowable’ under that schedule’ in accordance with Medicare coding policies and payment methodologies.

Make no mistake, insurers have consistently taken the position they are no longer obligated to pay the reimbursement rate listed in the participating physicians fee schedule, as it can use Medicare coding policies and payment methodologies to calculate the “allowable” amount the same way as Medicare does. *See e.g., State Farm Mut. Auto. Ins. Co. v. Pan Am Diagnostic Servs., Inc.*, 321 So. 3d 807 (Fla. 4th DCA 2021) (Insurer properly applied Medicare's Multiple Procedure Payment Reduction (MPPR) payment methodology on diagnostic services, which is authorized under PIP statute); *Progressive Am. Ins. Co. v. Head to Toe Posture Rehab, LLC*, 326 So. 3d 1158 (Fla. 3rd DCA 2021) (section 627.736(5)(a)3.'s plain language authorizes use of MPPR payment

methodology for reimbursement for therapy services); *Progressive Select Ins. Co. v. Dr. Rahat Faderani, DO, MPH, P.A.*, 330 So. 3d 928 (Fla. 4th DCA 2021) (Progressive properly applied NCCI edits in determining reimbursement, which are Medicare coding policies and payment methodologies allowed by section 627.736(5)(a) 3. in the reimbursement of PIP claims).

Allstate disputes the relevance of this section of the PIP statute, asserting that it is “permissive” and therefore implies it can be ignored. Allstate is once again, wrong. The court must give effect to all parts of the statute and avoid readings that would render a part thereof meaningless, and it must read all parts of a statute together in order to achieve a consistent whole. *Hardee Cty. v. FINR II, Inc.*, 221 So. 3d 1162, 1165 (Fla. 2017). To be clear, Plaintiff does not suggest an insurer is required to always use every any available Medicare coding policies and payment methodologies. However, with respect to CPT code 97039, Medicare determines reimbursement for services submitted exclusively by applying a specific Medicare payment methodology. Put another way, Medicare uses a payment methodology to “determine the *appropriate amount of reimbursement for medical services.*”

Logically, if a medically necessary service, reimbursable under Medicare Part B, can only be reimbursed using a Medicare payment methodology, then to determine the allowable amount under the MPFS, an insurer also needs to use that payment methodology. To be crystal clear, Plaintiff is **not arguing** Allstate has no other choice but to reimburse CPT code 97039 by using a Medicare payment methodology, as the PIP statute provides an alternative reasonable charge method for reimbursement that also satisfies the PIP statutes mandate. *See MRI Assocs.* at 583. (We have never held that the “reasonable charge method” and the “schedule of maximum charges” are mutually exclusive methods for determining the reasonableness of reimbursements).

Lastly, under Florida law, it is “a well settled principle that courts should avoid interpreting statutes in ways which ascribe to the legislature an intent to create an absurd result. *See McKibben v. Mallory*, 293 So.2d 48 (Fla.1974); *see also Dickinson v. Davis*, 224 So.2d 262, 264 (Fla.1969) (“It is never presumed that the Legislature intended to enact purposeless or useless legislation.”); *Allied Fidelity Ins. Co. v. State*, 415 So.2d 109, (Fla. 3d DCA 1982). *Ferre v. State ex rel. Reno*, 478 So. 2d 1077, 1082 (Fla. 3rd DCA 1985).

If this Court were to adopt Allstate’s interpretation and apply it, as suggested by Allstate, it takes little effort to imagine likely outcomes unintended by the legislature. For example, in determining that a service is only considered reimbursable when a CPT code has a set price, this would result in a blanket determination that any service billed using CPT code 97039 is automatically “not reimbursable under Medicare Part B.” It is hard to imagine the legislature intended to create a coverage mandate that “every PIP insurer is required to—that is, the insurer “shall”—reimburse eighty percent of reasonable expenses for **medically necessary services**,” *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*, 141 So. 3d 147, 155 (Fla. 2013), only to allow an insurer, like Allstate, to pre-determine that a service (billed under CPT code 97039) is not reimbursable, before it even knows what the service provided was.

On a similar vein, if the CPT code is what matters, and not the service provided, then what would the result be if a provider submits a bill for CPT 97039, for massage therapy, a non-reimbursable service under the PIP statute? §627.736(1)(a)5. Presumably, going solely by the CPT code, and not the service, it would be reimbursed at \$15.00 under workers’ compensation. Clearly, the legislature did not intend on providing a loophole for section §627.736(1)(a)5.

As demonstrated above, Allstate's interpretation of the statute is contrary to the statute's exclusive use of "service, supplies, or care" for reimbursement, binding case law, and most importantly, common sense.

B. Medicare Part B Reimburses CPT Code 97039 and Services Billed Under 97039

An interesting aspect of Allstate's statutory argument, and position that CPT code 97039 is not reimbursable under the MPFS, is the notion that "Medicare Part B confirms Allstate's reading of the statute." As it turns out, this too is nothing more than a specious argument which is rebutted by Allstate's own evidence.

Allstate begins its argument under the premise that when a Medicare Contractor reimburses a service (i.e., services submitted under CPT code 97039), its reimbursement is under the Medicare Part B Physician Fee Schedule. Allstate is mistaken for two reasons. First, Allstate misconprehends the role of a Medicare contractor, formally known as Medicare Administrative Contractors ("MAC"). Under Medicare Part B, there is no distinction between "Medicare" paying for a service and a "MAC" paying for a service, as all Medicare Part B payments flow through the MAC. To be sure, a cliff notes overview is as

follows:

- 42 CFR §421.400: § 1874A of the Social security Act “provides for the transition of the *claims processing functions and operations* for both Medicare Part A and Part B intermediaries and **carriers** to **Medicare Administrative Contractors (MACs)**. The transition will occur between October 1, 2005, and October 1, 2011. **MACs** will be fully operational in distinct, nonoverlapping geographic jurisdictions by **October 1, 2011**.
- 42 USC 1395kk-1(a)(4): Contracts with Medicare administrative contractors. (4) Functions Described:
 - (A) **Determination of payment amounts** – Determining (subject to the provisions of section 1395oo of this title and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this subchapter to be made to providers of services, suppliers and individuals.
 - (B) **Making payments**- Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).
- 42 USC 1395w-4(c): Determination of Relative Values for Physician Services.
 - (4)**Ancillary services**- the Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this section.
- 42 USC 1395u(a): Provisions relating to the administration of part B.
 - (a) In general. The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1395kk–1 of this title.

To summarize, under Medicare Part B, MACs exclusively handle claims processing and operations for all Medicare claims. See CFR §421.400. MACs are responsible for determining payments and making payments. 42 USC 1395kk-1(a)(4). The Secretary has the authority,

under section 42 USC 1395w-4(c), “determination of Relative Values for Physician services” to establish **ancillary** policies as may be necessary to implement this section. (i.e., Medicare payment methodology for 97039). Included in the Federal Register is Medicare’s payment methodology for services submitted under CPT code 97039, which is an example of an “ancillary policy” created by the Secretary as “necessary to implement this section.”

Importantly, the language included in the Federal Register does not state the payment methodology is for a MAC to make a “fact-based determination of reimbursement amounts,” as claimed by Allstate. (IB 36). Medicare’s payment methodology for services submitted under CPT code 97039 provides that a MAC determine an appropriate valuation, and notes that CPT code is given a Status C indicator:

For services coded using these unlisted codes, the provider includes a description of the specific procedure(s) that was furnished. The contractor uses this information to determine an **appropriate valuation**...To make the pricing methodology consistent with our policy for other unlisted services, and to more appropriately match payments with the actual resources expended to deliver the services provided, we proposed to have our contractors value CPT codes 97039 and 97139... We are finalizing our proposal and our contractors will value CPT code 97039 and 97139. We are assigning a **status indicator of “C”** to these two CPT codes.

70 Fed. Reg. 70160-61. (R1447-48).

Indeed, this also implicates another one of Allstate's arguments that "only RVUs associated with status codes 'A', 'R', and 'T', are use for Medicare payment." (IB8). This implies that *unless* a CPT code has a status code of 'A', 'R', and 'T', it is not used for Medicare payment, and therefore CPT code 97039 being a Status C code, is not part of the fee schedule. A review of Allstate's RJN of the Status Codes, confirms Allstate is wrong on both points:

A = **Active Code**. These codes are *paid separately under the physician fee schedule*, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = **Bundled Code**. Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, ***they are not used for Medicare payment***. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.

C = **Carriers price the code**. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

D = **Deleted Codes**. These codes are ***deleted*** effective with the beginning of the applicable year.

E = **Excluded from Physician Fee Schedule by regulation**. These codes are for items and/or services that CMS chose to *exclude from the fee schedule payment* by regulation. No RVUs are shown, and *no payment may be made* under the fee schedule for

these codes. Payment for them, when covered, generally continues under reasonable charge procedures.

F = **Deleted/Discontinued Codes**. (Code not subject to a 90 day grace period). These codes will *not appear on the 2006 file* as the grace period for deleted codes is no longer applicable.

G = **Not valid for Medicare purposes**. Medicare *uses another code for reporting of, and payment for*, these services. (Code subject to a 90 day grace period.)

H = **Deleted Modifier**. This code had an associated TC and/or 26 modifier in the previous year. For the current year, the TC or 26 component shown for the code has been deleted, and the deleted component is shown with a status code of "H".

I = **Not valid for Medicare purposes**. Medicare *uses another code for reporting of, and payment for*, these services.

J = **Anesthesia Services**. There are no RVUs and *no payment amounts* for these codes. The intent of this value is to facilitate the identification of anesthesia services.

M = **Measurement codes**. Used for reporting purposes only.

N = **Non-covered Services**. These services are *not covered by Medicare*.

P = **Bundled/Excluded Codes**. There are no RVUs and *no payment amounts* for these services. No separate payment should be made for them under the fee schedule.

R = **Restricted Coverage**. Special coverage instructions apply. If covered, the *service is carrier priced*.

T = **Injections**. There are RVUS and *payment amounts* for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same

provider, these services are bundled into the physician services for which payment is made.

X = **Statutory Exclusion**. These codes represent an item or service that is *not in the statutory definition of "physician services"* for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and *no payment may be made* under the physician fee schedule.

Q = **Therapy functional information code** (used for required reporting purposes only).

(R1626-7). As demonstrated above, there are only two categories of Status codes. Only one category receives payment under the Medicare Physician Fee schedule: Status A (*paid separately under the physician fee schedule*); Status C (Carriers will *establish RVUs and payment amounts*); Status R (If covered, the *service is carrier priced*); and Status T (There are *RVUs and payment amounts* for these services). The remaining Status codes fall into the second category which never receives payment.

Put into proper context, the statement that “only RVUs associated with status codes ‘A’, ‘R’, and ‘T’, are use for Medicare payment,” is actually referring to when a CPT code *does* have RVUs, but is not reimbursed under Medicare (i.e., Status B code: If RVUs are shown, **they are not used for Medicare payment**). Allstate’s assertion that for CPT code 97039, “a local Medicare contractor’s fact-based determination of

reimbursement amounts does not qualify under the PIP statute” is therefore demonstrably false, as reimbursement of a Status C code is still based on **RVUs**, except a Medicare Contractor establishes “RVUs and payment amounts” based on the specific service provided.

In summation, using the same Social Security Act, statutes, and Allstate’s own evidence, Plaintiff has demonstrated that when a MAC reimburses a service, they are performing their **exclusive** statutorily role under Medicare Part B-of **receiving claims, determining payment and making payments.**

Under this framework, Allstate has articulated no basis and provided no evidence to deem CPT code 97039, which is Carrier Priced by the Medicare contractor who establishes RVUs, as not being reimbursable under the MPFS. Allstate’s only remaining point is that CPT code 97039 has no set price, and to determine the allowable amount requires Allstate to actually process the claim based on the service provided, which is what they are already required to do already for PIP claims.

III. THE TRIAL COURT CORRECTLY GRANTED FINAL SUMMARY JUDGMENT TO PLAINTIFF BECAUSE THERE WAS NO GENUINE ISSUES OF MATERIAL OF FACT AND SUMMARY JUDGMENT WAS WARRANTED BASED ON CONSIDERATION OF ALL RECORD EVIDENCE

A. The Parties Summary Judgment Burdens

Allstate overinflates Plaintiff's burden in this case, insinuating the evidence must prove "exactly" how Medicare would reimburse the service. Allstate is wrong. Plaintiff's burden in the case was to prove its expenses for medical services were reasonable, related and medically necessary. Allstate admitted the services were related and medically necessary. Plaintiff agreed Defendant's policy may limit reimbursement under the schedule of maximum charges, and Defendant asserted its payment for the services at issue were pursuant to the schedule of maximum charges.

Accordingly, relatedness, medical necessity and reasonableness are not part of Plaintiff's burden. Plaintiff's only burden was to prove damages. Plaintiff met its burden of proof by applying Medicare's payment methodology and providing competent, substantial evidence that an appropriate value and allowable amount for the Hydrobed therapy under Medicare Part B is \$37.62, which is greater than the

\$15.00 Allstate improperly allowed under workers' compensation.

Allstate on the other hand did not meet its burden of proving its affirmative defense of proper payment. An affirmative defense is an assertion of facts or law by the defendant that, if true, would avoid the action and the plaintiff is not bound to prove that the affirmative defense does not exist. *See Langford v. McCormick*, 552 So. 2d 964, 967 (Fla. 1st DCA 1989). *See also Storchwerke, GMBH v. Mr. Thiessen's Wallpapering Supplies, Inc.*, 538 So. 2d 1382, 1383 (Fla. 5th DCA 1989); Black's Law Dictionary 482 (9th ed. 2009). The defendant has the burden of proving an affirmative defense. *See Hough v. Menses*, 95 So. 2d 410, 412 (Fla. 1957). *See also, Dorse v. Armstrong World Industries, Inc.*, 513 So. 2d 1265, 1269 n.5 (Fla. 1987) (recognizing that the burden of proving each element of an affirmative defense rests on the party that asserts the defense).

Allstate's position was that it could determine under worker's compensation based solely on the CPT code utilized. Since Allstate's entire argument hangs on reimbursing under workers' compensation, which they are prohibited from using when Hydrobed therapy is related, medically necessary, and a reimbursable service, Allstate failed to prove their proper payment defense.

B. Final Summary Judgment was Warranted Based on Consideration of All Record Evidence and Allstate's Failure to Demonstrate Reversible Error

As this Court has previously held, “in reviewing a final judgment rendered from a non-jury trial, the trial court's findings of fact are clothed with a presumption of correctness. *Fito v. Attorney's Title Ins. Fund, Inc.*, 83 So.3d 755, 757-58 (Fla. 3d DCA 2011). We apply a clear error standard to the findings of fact, and a finding will not be disturbed unless it is totally unsupported by competent and substantial evidence, it is clearly against the weight of the evidence, or it was induced by an erroneous view of the law. *Id.*; *Holland v. Gross*, 89 So.2d 255, 258 (Fla. 1956).” *La Ley Sports Complex at City of Homestead, LLC v. City of Homestead*, 255 So. 3d 468, 469 (Fla. 3rd DCA 2018).

In this case, Plaintiff and Allstate both asserted there were no disputed issues of fact, and the issue before the trial court was a legal determination. Allstate did not object to the admissibility of Plaintiff's evidence. Allstate *admitted* the services were related and medically necessary. Allstate filed *no evidence* disputing the service was reimbursable under Medicare Part B. Allstate *admitted* the service was reimbursable under Medicare “generally.” Allstate provided *no evidence* that another dollar amount for reimbursing Hydrobed therapy under the

MPFS. The undisputed record evidence demonstrated that Hydrobed therapy, billed using CPT code 97039, was related, medically necessary, and a reimbursable service under Medicare Part B.

Plaintiff met its burden of proof by applying Medicare's payment methodology and providing competent, substantial evidence that a reasonable value and allowable amount for the Hydrobed therapy under Medicare Part B is \$37.62, which is greater than the \$15.00 Allstate improperly allowed under workers' compensation.

Allstate on the other hand did not meet its burden of proving its affirmative defense of proper payment. Allstate's position was that it could determine reimbursement based solely on the CPT code utilized. Allstate argued that because CPT code 97039 has no set price, it is not reimbursable under the MPFS. According to Allstate, this allowed them to reimburse \$15.00 under worker's compensation, without having to determine if the service itself was reimbursable under Medicare.

On the record before it, the trial court correctly applied the summary judgment standard, correctly applied section 627.736(5)(a)1., and correctly granted Plaintiff final summary judgment based on the undisputed record evidence. The Final Judgment should therefore be affirmed.

CONCLUSION

It is respectfully submitted that the final judgment entered below should be affirmed.

CERTIFICATE OF FILING AND SERVICE

We hereby certify that in compliance with Fla. R. Jud. Adm. 2.515, on January 22, 2024, this Brief was electronically filed at the Florida Courts E-Portal.

We further certify that in compliance with Fla. R. Jud. Adm. 2.516, on January 22, 2024, this Brief was electronically served on Garrett A. Tozier, Esq., Shutts & Bowen, LLP, at GTozier@shutts.com, allstateservice@shutts.com and Todd Landau, Esq., Todd Landau, P.A., at pleadings@toddlandalaw.com.

CERTIFICATE OF COMPLIANCE

I HEREBY CERTIFY that this brief complies with the applicable font and word count limitations set forth in Florida Rule of Appellate Procedure 9.210(a)(2)(B).

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