

**IN THE SUPREME COURT  
STATE OF FLORIDA**

**CASE NO. SC12-477**

GEICO INDEMNITY COMPANY,

Petitioner,

v.

VIRTUAL IMAGING SERVICES, INC., a/a/o Mereles Gomez,

Respondent.

On Review from the Third District Court of Appeal,  
Case No. 3D10-2595

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**PETITIONER'S BRIEF ON JURISDICTION**

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## TABLE OF CONTENTS

|   |    |
|---|----|
| TABLE OF CITATIONS .....  | i  |
| INTRODUCTION .....  | 1  |
| THE HOLDINGS IN <i>VIRTUAL I</i> .....  | 2  |
| BASIS FOR CONFLICT JURISDICTION.....  | 3  |
| I. <i>Virtual I</i> Conflicts With <i>Allstate Insurance Co. v. Holy Cross Hospital, Inc.</i> , 961 So. 2d 328 (Fla. 2007) .....    | 1  |
| A. <i>Virtual I</i> Requires Insurers to ‘Elect’ the Fee Schedules .....  | 4  |
| B. <i>Virtual I</i> Construction is Unfavorable to Insureds .....   | 6  |
| C. <i>Virtual I</i> Conflicts With <i>Holy Cross</i> Because (1)(a) Does Not<br>Mandate Payment at 80% of the ‘Amount Billed’ ..... | 7  |
| II. <i>Virtual I</i> Abandons Basic Principles of Statutory Construction .....  | 8  |
| III. <i>Virtual I</i> Conflicts With <i>Kingsway</i> .....  | 9  |
| CONCLUSION .....  | 10 |
| CERTIFICATE OF SERVICE .....  | 12 |
| CERTIFICATE OF FONT SIZE .....  | 13 |

## **TABLE OF CITATIONS**

### **Cases**

|   |      |
|---|------|
| <i>Century Vill., Inc. v. Wellington Condo. Ass’n</i> ,<br>361 So.2d 128 (Fla. 1978) .....          | 9    |
| <i>Ford Motor Co. v. Kikis</i> ,<br>401 So. 2d 1341 , 1342 (Fla. 1981) .....                        | 1    |
| <i>GEICO Gen. Ins. Co. v. Virtual Imaging Svcs., Inc.</i><br>Case No. 3D11-581 .....                | 1    |
| <i>Grant v. State Farm Fire &amp; Cas. Co.</i> ,<br>638 So.2d 936 (Fla. 1994) .....                 | 6, 9 |
| <i>Grant</i> ,<br>638 So. 2d at 938 .....   | 9    |
| <i>Gulfstream Park Racing Ass’n. v. Tampa Bay Downs, Inc.</i> ,<br>948 So. 2d 599 (Fla. 2006) ..... | 9    |
| <i>Malu v. Sec. Nat’l Ins. Co.</i> ,<br>898 So. 2d 69 (Fla. 2005) .....                             | 6    |
| <i>Nationwide Mut. Ins. Co. v. Jewell</i> ,<br>862 So. 2d 79 (Fla. 2d DCA 2003) .....               | 6    |
| <i>State v. Iacovone</i> ,<br>60 So. 2d 1371 (Fla. 1995) .....                                      | 9    |

### **Statutes**

|                         |   |
|-------------------------|---|
| §627.736(1)(a) .....    | 7 |
| §627.736(5)(a)(2) ..... | 3 |
| §627.736(5)(a)1 .....   | 8 |
| §627.736(5)(a)2 .....   | 8 |
| §627.736(5)(a)2.f ..... | 2 |

### **Other Authorities**

|                                    |   |
|------------------------------------|---|
| Art. V, §3(b)(3), FLA. CONST. .... | 1 |
|------------------------------------|---|

### **Rules**

|  |   |
|--|---|
| Fla. R. App. P. 9.030(a)(2)(A)(iv) ..... | 1 |
|--|---|

|                                  |    |
|----------------------------------|----|
| Fla. R. App. P. 9.210(a)(2)..... | 13 |
|----------------------------------|----|

## INTRODUCTION

Petitioner respectfully requests this Court to exercise its discretionary jurisdiction under Art. V, §3(b)(3), Fla. Const. and Fla. R. App. P. 9.030(a)(2)(A)(iv) to review *GEICO Indem. Co. v. Virtual Imaging Svcs., Inc.*, --- So.3d ----, 2011 WL 5964369 (Fla. 3d DCA Nov. 30, 2011) (“*Virtual I*”), in which the Third District answered the following certified question of great public importance in the negative:

May an insurer limit provider reimbursement to 80% of the schedule of maximum charges described in F.S. 627.736(5)(a) if its policy does not make a specific election to do so?

*Virtual I*, at \*1.<sup>1</sup> The Third District relied on *Kingsway Amigo Ins. Co. v. Ocean Health, Inc.*, 63 So. 3d 63 (Fla. 4th DCA 2011),<sup>2</sup> petition for discretionary review pending, Case No. SC11-1581.<sup>3</sup> For reasons in addition to and independent of those presented in the *Kingsway* petition, this Court should exercise its

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<sup>1</sup> This same certified question is pending before the Third District in *GEICO Gen. Ins. Co. v. Virtual Imaging Svcs., Inc.*, Case No. 3D11-581 [“*Virtual II*”]. Oral argument was held on March 5, 2012.

<sup>2</sup> *Kingsway* addressed a similar certified question: whether an insurer may “elect to use” the fee schedules when the policy provides coverage for 80% of reasonable medical expenses. 63 So. 3d at 64.

<sup>3</sup> This Court’s discretionary jurisdiction also has been sought in two *per curiam* affirmances based on *Kingsway*: (1) Case No. SC12-3, *United Auto. Ins. Co. v. Hallandale Beach Orthopedics, Inc.* and (2) Case No. SC12-105, *United Auto. Ins. Co. v. Millennium Radiology, LLC*.

discretionary conflict jurisdiction<sup>4</sup> here because the legal holdings in *Virtual I* conflict with established precedent and contravene fundamental principles of statutory construction.

### **THE HOLDINGS IN VIRTUAL I**

In *Virtual I*, the Third District<sup>5</sup> held that personal injury protection (“PIP”) insurers may not limit provider reimbursements in accordance with the Medicare fee schedules, as authorized by §627.736(5)(a)2.f, if the policy does not make a specific election to do so. Relying on *Kingsway*, the majority determined that the PIP statute “afford[s] insurers a choice between two different payment calculation methodologies” – reimbursing the provider for (1) “80% of the amount billed” or (2) “80% of 200% of the amount listed on the Medicare fee schedule.” *Virtual I*, at \*2. Under this dual-methodology framework, the Third District analyzed “whether there is a conflict between the language of the policies...and the PIP statute.” *Id.*

The Court declared the policy (which provides coverage for 80% of reasonable medical expenses) ambiguous because it did not “clarify[] alternative

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<sup>4</sup> Conflict jurisdiction exists where “the precedential effect of those decisions which are incorrect . . . conflict with decisions reflecting the correct rule of law.” *Wainwright v. Taylor*, 476 So. 2d 669, 670 (Fla. 1985) (citations omitted). It is not necessary that the conflict be expressly recognized in the district court opinion. *See Ford Motor Co. v. Kikis*, 401 So. 2d 1341, 1342 (Fla. 1981).

<sup>5</sup> The panel consisted of Judges Cortiñas and Rothenberg of the Third District, and Judge Levine from the Fourth District. Judge Cortiñas authored the panel decision in which Judge Levine joined. Judge Rothenberg dissented with opinion.

methods or identify[] the factors to be considered in selecting among [reimbursement] methods.” *Id.* The Court determined that “ambiguities necessarily result” from incorporating the statutory fee schedules to a policy that provides coverage for 80% of reasonable medical expenses. *Id.* The Court also found the PIP statute ambiguous because “the permissive language” of (5)(a)(2) “itself creates ambiguity.” *Id.* The Court reasoned that a statutory “provision indicating that an insurer may limit reimbursements leaves unclear whether this option will be exercised, and therefore provides no indication to policyholders . . . the amount the insurer will pay for necessary medical services.” *Id.* (emphasis in original).

Resolving these “ambiguities” favorably to the provider (as the insured’s assignee), the Court held that “even if GEICO were correct that 627.736(5)(a)(2) is incorporated to the policies, the resulting ambiguity regarding which methodology GEICO would use...supports the conclusion that GEICO should have reimbursed Virtual Imaging for the greatest amount possible within the language of the policies.” *Id.*

### **BASIS FOR CONFLICT JURISDICTION**

#### **I. *Virtual I Conflicts With Allstate Insurance Co. v. Holy Cross Hospital, Inc.*, 961 So. 2d 328 (Fla. 2007)**

In *Holy Cross*, this Court addressed the issue of whether reimbursing PIP providers at reduced preferred provider (“PPO”) rates violates the mandatory minimum coverage requirement of subsection (1)(a) – 80% of reasonable medical

expenses. *Holy Cross*, 961 So. 2d at 335. In holding that an insurer may reimburse a provider at the lower PPO rate instead of 80% of the amount billed, this Court established that insurers may reimburse providers at reduced rates if authorized by the PIP statute – regardless of whether such statutory authorization is mentioned in or is part of the PIP policy – and that such reduced payments do not violate the mandatory coverage requirement of the PIP statute.

A. *Virtual I Requires Insurers to ‘Elect’ the Fee Schedules.*

In *Holy Cross*, the insurer reimbursed a PIP provider at a reduced PPO rate. The provider sued, asserting that, under subsection (1)(a), the insurer “could not take advantage of any reduced rates and was required to pay eighty percent of all reasonable medical expenses, *i.e.*, eighty percent of the full bill as charged...,” because the insureds did not have PPO policies, and the insurer and the provider had no direct PPO contract. *Id.* at 331. This Court rejected that argument and held:

Payment at a reduced rate does not violate subsection (1)(a) so long as the insurer pays eighty percent of all *reasonable* expenses. What a provider customarily charges or has previously accepted are important factors for determining whether a fee is reasonable. This is especially true where the provider has agreed to accept a certain fee as a reasonable payment [for particular services].

*Id.* at 335 (emphasis in original)(citations omitted).

In so holding, this Court determined that the provider had “agreed to accept” the reduced PPO rate because it had contracted with a PPO network (Beech Street),



and Beech Street had a separate PPO agreement with the insurer. *Holy Cross*, 961 So. 2d at 330. Without an ‘election’ or any reference to the PPO payment ‘methodology’ in the policy,<sup>6</sup> and notwithstanding the absence of a direct contract between provider and insurer, this Court concluded that the insurer could reimburse the provider at the reduced PPO rate, and that the reduced payment did not violate subsection (1)(a)’s mandatory coverage requirement (80% of reasonable medical expenses). *Id.* at 330, 335-36.

*Virtual I* concludes that PIP insurers cannot limit provider reimbursements in accord with the statutorily authorized Medicare fee schedules without ‘electing’ to do so in the policy. This conflicts with *Holy Cross* because the PPO framework is functionally equivalent to Medicare, under which providers routinely accept pre-set reduced rates for particular services. *See Holy Cross*, 961 So.2d at 335-336 (recognizing that “[w]hat a provider customarily charges or has previously accepted are important factors for determining whether a fee is reasonable,” and holding that the indirect PPO arrangement created an “agreed upon fee schedule,” the effect of which was “to predetermine...a ‘reasonable expense’ for a covered service”) (citations omitted).

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<sup>6</sup> The policy at issue in *Holy Cross* was a standard PIP policy and did not mention PPO arrangements or provider reimbursement at reduced rates. *Id.* at 331.

The circumstances in *Virtual I* are even more compelling than in *Holy Cross* because (a) the ‘reduced rate’ is based not on a separate contract, but on an express statutory provision in which the Legislature authorized insurers to limit provider reimbursements under the Medicare fee schedules; and (b) the provider in *Virtual I* took the benefits assignment after the statutory fee schedule provisions were enacted and thus with full knowledge of the reimbursement limitations authorized thereby.<sup>7</sup> *Virtual I*’s ‘election’ requirement cannot be reconciled with *Holy Cross*.

B. *Virtual I* Construction is Unfavorable to Insureds.

*Virtual I* identifies the correct principle of law – ambiguities are resolved favorably to insureds. *Virtual I*, at \*2.<sup>8</sup> However, by concluding that paying PIP providers the “greatest amount possible” favors insureds, the Court incorrectly applied this principle. *Id.* This is contrary to *Holy Cross*, and the underlying opinions of *Nationwide Mut. Ins. Co. v. Jewell*, 862 So. 2d 79 (Fla. 2d DCA 2003) [“*Jewell*”] and *Allstate Ins. Co. v. Holy Cross Hosp., Inc.*, 895 So. 2d 1241 (Fla. 4th DCA 2005) [“*Allstate*”], which this Court approved in *Holy Cross*.

As the Second District explained in *Jewell*, reimbursing PIP providers at statutorily authorized reduced rates **benefits** insureds:

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<sup>7</sup> See *Grant v. State Farm Fire & Cas. Co.*, 638 So.2d 936, 938 (Fla. 1994).

<sup>8</sup> E.g., *Malu v. Sec. Nat’l Ins. Co.*, 898 So. 2d 69, 74 (Fla. 2005) (“the PIP statute should be interpreted liberally to effectuate the legislative purpose of providing broad PIP coverage for Florida motorists.”).

Any contractual arrangements the insurers have made for paying certain providers at PPO rates have in no way adversely affected the services made available to the insureds under the PIP policies...since each treatment provided by a PPO provider costs the insurer less than the same treatment given by a non-PPO provider, *more services* will be available to the insured within the \$10,000 PIP policy limits.

862 So. 2d at 86 (emphasis in original). The Fourth District followed *Jewell* in *Allstate*, 895 So. 2d at 1244. *Jewell/Allstate* establish that reimbursing providers at reduced rates favors insureds because more services are available within the \$10,000 mandatory coverage limits. This Court approved this precise rationale. *Holy Cross*, 961 So. 2d at 335 (approving *Jewell* and *Allstate*). Accordingly, *Virtual I* directly conflicts with *Jewell*, *Allstate*, and *Holy Cross*.

C. *Virtual I* Conflicts With *Holy Cross* Because (1)(a) Does Not Mandate Payment at 80% of the ‘Amount Billed’.

In *Holy Cross*, this Court established that the PIP statute does not require an insurer to pay 80% of the amount billed. There, the provider argued that the insurer must “pay eighty percent of all reasonable medical expenses, *i.e.*, eighty percent **of the full bill as charged**, as set forth in Section 627.736(1)(a).” *Holy Cross*, 961 So. 2d at 331 (emphasis added). Rejecting that assertion, this Court reiterated that subsection (1)(a) only requires an insurer to pay “eighty percent of all *reasonable expenses*.” *Id.* at 335 (emphasis in original). Thus, *Holy Cross* established that “reasonable expenses” does not mean “billed amount.”

*Virtual I* holds just that. The Third District’s conclusion that (1)(a) requires payment at 80% of the billed amount is premised on the impractical legal fictions that the PIP statute contains two payment methodologies and that an ‘insured-favorable’ construction requires paying providers the greatest possible amount. These legal determinations directly conflict with the holdings of *Holy Cross*.

## **II. *Virtual I* Abandons Basic Principles of Statutory Construction.**

The *Virtual I* majority’s interpretation of the PIP statute violates several well-established principles of statutory construction. **First**, the conclusion that subsection (1)(a) requires payment at the rate of 80% of the amount billed renders subsections (5)(a)1 and (5)(a)2 meaningless.<sup>9</sup> This is so because if “reasonable expenses” under subsection 1(a) means “amount billed,” there is no need to consider “factors” in determining reasonableness, which is the lone purpose of (5)(a)1. And, the conclusion renders (5)(a)2 meaningless because payment in any amount below 80% of the billed amount *ipso facto* violates the mandatory coverage requirement of (1)(a). It is axiomatic that a statute cannot be interpreted to render express provisions meaningless or produce an absurd result. *E.g.*, *State v. Iacovone*, 660 So. 2d 1371, 1373 (Fla. 1995).

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<sup>9</sup> This conclusion misapprehends the difference between coverage requirements and provider payment obligations. As this Court explained, subsection 1(a) “outlines the coverage that PIP insurers must provide” (80% of reasonable medical expenses) and subsection (5) sets forth “strict guidelines for both PIP insurers and medical providers” as to charges and benefits payments. *Holy Cross*, 961 So. 2d at 332.

**Second**, *Virtual I*'s ambiguity finding necessitated a review of the legislative intent<sup>10</sup> behind the PIP statute – an analysis that overwhelmingly supports application of the fee schedules to limit provider reimbursements. *See Virtual I*, at \*6-9 (Rothenberg, J., dissenting). The *Virtual I* majority overlooked this fundamental tenet of statutory construction and disregarded the comprehensive legislative history.

**Third**, by declining to treat the fee schedules as incorporated to the policy, the *Virtual I* majority abandoned the basic statutory construction principles of ‘incorporation by law’ and ‘incorporation by reference.’ *See Grant v. State*, 638 So. 2d at 938 (incorporation by law); *Century Vill., Inc. v. Wellington Condo. Ass’n.*, 361 So. 2d 128, 133 (Fla. 1978) (incorporation by reference); *Virtual I*, at \*5 (Rothenberg, J., dissenting).

### **III. *Virtual I* Conflicts With *Kingsway***

*Virtual I*'s finding that the policy would be rendered ambiguous upon incorporation of the fee schedules is in direct conflict with *Kingsway*. *Kingsway* found the PIP statute unambiguous, and concluded that insurers may use the fee schedules if the policy “clearly and unambiguously select[s] that payment methodology.” *Kingsway*, 63 So.3d at 67.

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<sup>10</sup> *E.g.*, *Gulfstream Park Racing Ass’n. v. Tampa Bay Downs, Inc.*, 948 So. 2d 599, 606 (Fla. 2006) (reviewing legislative history to determine legislative intent and resolve statutory ambiguity).

But under *Virtual I*, an insurer may not use the fee schedules – even if they are incorporated to the policy. This is because under *Virtual I*, inclusion of the statutory ‘permissive’ language authorizing use of the fee schedules renders the policy ambiguous. And given *Virtual I*’s ‘insured-favorable’ construction of the resulting “ambiguity,” insurers must pay providers the “greatest amount possible” under the policy, *i.e.*, 80% of the billed amount. *Virtual I*, at \* 2. Thus, incorporation of the fee schedules to the policy is pointless, notwithstanding the holding of *Kingsway*.

### **CONCLUSION**

This Court should accept discretionary jurisdiction because *Virtual I* conflicts with previous decisions of other district courts of appeal and with decisions of this Court.

Respectfully submitted,

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