In the Florida Supreme Court

MRI ASSOCIATES OF TAMPA, INC., d.b.a. Park Place MRI,

Petitioner,

vs.

Case No. SC18-1390

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Respondent.
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PETITIONER'S MOTION FOR REHEARING OR CLARIFICATION

Pursuant to Florida Rules of Appellate Procedure 9.300 and 9.330, the Petitioner, MRI Associates of Tampa, Inc., doing business as Park Place MRI, hereby moves for rehearing or clarification concerning this Honorable Court's appellate opinion and its order denying the Petitioner's motion for appellate attorneys' fees, both of which were issued on December 9, 2021. In support of this motion, the Petitioner states:

A. Introduction

1. This appeal involves a question that was certified as a matter of great public importance by the Second District in *State Farm Mutual Automobile Insurance Co. v. MRI Associates of Tampa, Inc.*, 252 So. 3d 773 (Fla. 2d DCA 2018), involving medical expenses covered by personal injury

protection ("**PIP**") insurance.

2. In the trial court, State Farm sued the Petitioner for declaratory relief concerning 19 claims for PIP benefits for medical expenses incurred by 19 of its patients who were insured by State Farm (R 8-116).[1] The Petitioner responded with a counterclaim against State Farm for declaratory judgment and other relief (R 152-169, 176-197). The parties subsequently filed competing motions for summary judgment (R 453-524), which were based on and governed by a limited set of stipulated undisputed facts (R 170-175, 207-370). Based on those stipulated facts (R 1163, ¶3), trial court denied State Farm's motion, granted the Petitioner's motion, and held that State Farm's Policy Form 9810A does not "lawfully invoke[ ] the Schedule of Maximum Charges and payment calculation methodology set forth in section 627.736(5)(a)1-5, Florida Statutes (2012-2015)" (R 1176).

3. State Farm appealed to the Second District (R 1171-1173). In *State Farm Mut. Auto. Ins. Co. v. MRI Associates of Tampa, Inc.,* 252 So.3d 773 (Fla. 2d DCA 2018), the Second District reversed the trial court's decision, but its decision was primarily based on arguments raised *sua sponte* by the Second District itself (i.e., the Legislature's renumbering of the PIP statute's

[1] Citations herein to **"R"** refer to the original record on appeal of the trial court proceedings. Citations to **"RII"** refer to the record of the appellate proceedings in the Second District.

subsections), that State Farm never raised or preserved, and that the parties were never given the opportunity to brief. Notably, the Second District's decision was not based on any analysis of Section 627.736(5)(a)5, Florida Statutes (2012-present).

4. Based on the question that the Second District's decision had certified as a matter of great public importance,[2] the Petitioner sought discretionary review from this Court, and asserted that the Second District's decision was based on arguments that were never raised by State Farm, were waived, and could not serve as a lawful basis for reversal of the trial court's judgment, and that the Second District's basis for reversal was otherwise incorrect. *See, e.g.,* Petitioner's Corrected Am. Initial Brief at p. 11-12 (filed 4/23/2020).

5. At page 11, this Court's Opinion acknowledges that, in this iteration of the appellate process, "the arguments the parties present to us center on the analysis adopted by the district court." Consistent with the

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[2] The certified question was, "DOES THE 2013 PIP STATUTE AS AMENDED PERMIT AN INSURER TO CONDUCT A FACT–DEPENDENT CALCULATION OF REASONABLE CHARGES UNDER SECTION 627.736(5)(a) WHILE ALLOWING *779 THE INSURER TO LIMIT ITS PAYMENT IN ACCORDANCE WITH THE SCHEDULE OF MAXIMUM CHARGES UNDER SECTION 627.736(5)(a)(1)?" Notably, the certified question does not address the notice requirements of Section 627.736(5)(a)5. *MRI Associates,* 252 So.3d at 778.

Petitioner's briefing in this Court, this Court's Opinion rejected the Second District's reasons for reversing the trial court, and stated, "we are not persuaded that the reorganization of the statute relied on by the Second District is a sound basis for determining the issue presented in this case...." *See,* Opinion at p. 16. However, instead of reversing the Second District's decision, this Court then approved "the result reached" by the Second District, based on an analysis of the "notice" requirements contained in the first sentence of Section 627.736(5)(a)5, which was never raised by State Farm in the trial court or in the Second District, not addressed by the Second District's analysis, or by State Farm in its answer brief to this Court.[3]

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[3] Like the Second District's decision below, State Farm's motion for summary judgment (R 495, 500, 506-513), its briefs in the Second District (RII 121, 134-136, 877-879), and its answer brief to this Court do not raise the specific requirements imposed by the first sentence of Section 627.736(5)(a)5. Instead, State Farm addressed the second sentence of Section 627.736(5)(a)5, and contended that State Farm's policy form 9810A was approved by the Florida Office of Insurance Regulation. *See*, State Farm's Answer Brief (filed 10/25/2019) at p. 17, 30-32. That issue was thoroughly briefed in the trial court and in the Second District, and was not a basis of the Second District's reversal. In its reply brief to this Court, the Petitioner argued, among other things, that "Section 627.736(5)(a)5 allows insurers to rely on the schedule of maximum changes 'only' if the insurance policy has 'a notice at the time of issuance or renewal' of intent to limit payments 'pursuant to' the fee schedule. Here, there is no evidence State Farm provided any of the 19 insured patients such 'a notice at the time of issuance or renewal' or that the policy agrees to pay anything 'pursuant to' the fee schedule." *See*, Petitioner's Reply Brief on the Merits, at p. 7 (filed on 1/3/2020).

6. The Petitioner respectfully submits that, like the Second District's decision below, this Court's decision reverses the trial court's decisions based on arguments that State Farm never preserved in the trial court or presented in the Second District, and which were not preserved for appeal as a basis for reversing the trial court's judgment. In addition, this Court has overlooked or misapprehended the undisputed facts of this case, as well as the plain and complete text of the PIP statute (§627.736, Fla. Stat.) as amended in 2012.

7. As a result, this Court's opinion gives State Farm and other insurers doing business in Florida the ability to sell illusory PIP insurance coverage that leaves insureds, their health care providers, and the courts with no way to objectively predict, determine, or enforce the precise amount that health care provider can charge and collect, that State Farm must pay, and that insured patients must pay, for medical expenses incurred by insured patients.

8. The arguments herein are made in good faith, with the undersigned attorneys' genuine beliefs in the merits of this motion and with confidence that this Court desires to achieve the correct result and provide clear direction to insureds, health care providers, insurers, and lower courts.

B. This Court and the Second District have reversed the trial court based on arguments that were never raised by State Farm

9. For the second time in two consecutive appeals, the Petitioner is

once again faced with an appellate opinion which reverses the trial court's judgment based on arguments that State Farm never preserved as a basis for reversing the trial court's judgment.

10. It is well-settled that an appellate court will not consider arguments not presented to the trial judge. *Dober v. Worrell*, 401 So.2d 1322, 1323-24 (Fla.1981). To preserve an argument on appeal as a basis to reverse the trial court's judgment, that argument must first be presented to the trial judge. *See, e.g., City of Orlando v. Birmingham,* 539 So.2d 1133, 1134-35 (Fla. 1989). Moreover, appellate review is limited to the same specific grounds raised in the trial court. *See e.g., Chamberlain v. State*, 881 So.2d 1087, 1100 (Fla. 2004).

11. It is "inappropriate" for appellate court to depart from role of neutral tribunal and develop arguments that have not been presented; rather, the appellate court should "work within the framework of the briefs." *See Manatee County School Board v. NationsRent, Inc.,* 989 So.2d 23, 25 (Fla. 2d DCA 2008). *See also, City of Miami v. Steckloff*, 111 So.2d 446, 447 (Fla.1959) ("points covered by a decree of the trial court will not be considered by an appellate court unless they are properly raised and discussed in the briefs"); *Castor v. State*, 365 So.2d 701, 703 (Fla. 1978) ("As a general matter, a reviewing court will not consider points raised for the

first time on appeal."); *Branch Banking & Trust Co. v. Kraz, LLC*, 114 So.3d 273, 275, n. 3 (Fla. 2d DCA 2013) (arguments not raised in initial brief "are not properly before this court"); *J.A.B. Enters. v. Gibbons*, 596 So.2d 1247, 1250 (Fla. 4th DCA 1992) ("an issue not raised in an initial brief is deemed abandoned").

12. When a court *sua sponte* decides issues that are not raised by the parties, it is a violation of procedural due process. *See, e.g., Rucker v. Just Brakes*, 75 So. 3d 807, 808 (Fla. 1st DCA 2011); *Lobree v. ArdenX LLC*, 199 So. 3d 1094, 1098 (Fla. 3d DCA 2016); *Nat'l City Bank v. Nagel*, 95 So. 3d 458, 459 (Fla. 4th DCA 2012); *GMAC Mortg., LLC v. Choengkroy*, 98 So.3d 781, 782 (Fla. 4th DCA 2012); *Liton Lighting v. Platinum Television Group, Inc.*, 2 So.3d 366, 367 (Fla. 4th DCA 2008); *Williams v. Primerano*, 973 So. 2d 645, 647 (Fla. 4th DCA 2008) .

13. The bases for reversing the trial court's decision expressed in the appellate opinions issued by the Second District and this Court were not raised by State Farm, were waived by State Farm, and could not serve as a lawful basis for reversing the trial court's judgment. As a result, both decisions effectively offer an advisory opinion on issues never raised as a basis for reversing the trial court.

14. For all intents and purposes, an appellate court's reversal of a trial

court's decision based on arguments never raised by the party seeking reversal presents an "anti" tipsy coachman approach to appellate review. Under the tipsy coachman doctrine, an appellate court should affirm the trial court's judgment if the trial court reached the right result but for the wrong reasons. *See, e.g., Dade County School Bd. v. Radio Station WQBA,* 731 So.2d 638, 644 (Fla. 1999). Under that doctrine, it is the appellee (i.e., the party seeking to affirm the trial court's judgment), not the appellant (i.e., the party seeking to reverse the trial court's judgment) that may present arguments not previously raised in the trial court. *See, Malu v. Sec. Nat'l Ins. Co*, 898 So.2d 69, 73 (Fla. 2005).

15. The Fourth District explained this problem in *Advanced Chiropractic & Rehab. Ctr. Corp. v. United Auto. Ins. Co.,* 103 So.3d 866, 868-869 (Fla. 4th DCA 2012). In that case, a circuit court appellate panel reversed a county court's decision on grounds that were not raised by the appellate briefs. On its own initiative, the circuit court *sua sponte* relied on an unpreserved argument to reverse the county court's trial-level decision. The Fourth District subsequently quashed the circuit court's appellate decision and held:

> [The appellee-plaintiff] has filed a second-tier petition for writ of certiorari directed at a decision of the appellate division of the circuit court. The circuit court reversed county court final orders on an issue that was neither preserved in the county court nor

raised in the appellant's brief on appeal. Because **this amounts to a denial of due process**, we grant the writ, quash the appellate decision of the circuit court, and remand for reinstatement of the county court orders.

. . . . .

The...appellate panel of the circuit court reversed the county court order on grounds different from those raised by [the appellant-defendant] in its brief. ...

. . . . .

An appellate court's reversal based on an unpreserved error, on a ground not argued in a brief, amounts to a denial of due process, which is a departure from a clearly established principle of law. ...Here, [the appellant-defendant] waived the [arguments] relied upon by the circuit court to reverse by not raising objections at the hearing ... [and] did not rely on those purported errors as a basis for reversal in its appellate brief in the circuit court. <u>This is a case of "double waiver."</u>

. . . . .

... We note that the circuit court could not have reversed based upon the tipsy coachman doctrine. That 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." ...The tipsy coachman doctrine does <u>not</u> permit a reviewing court to <u>reverse</u> on an unpreserved and unargued basis.

Advanced, 103 So.3d at 868-869 (emphasis added; citations omitted). This same reasoning should govern the instant case, and prevents the trial court's judgment from being reversed on unpreserved arguments presented for the first time by the appellate court in its written opinion.

C. Timeline of events

16. Assuming arguendo that the Court's basis for reversing the trial

court's decision is preserved in record, it also appears that this Court's Opinion overlooks or misapprehends the relevant sequence of events.

17. In this regard, it is especially important to note that State Farm submitted its proposed new insurance policy form 9819A to the Florida Office of Insurance Regulation ***before*** the creation of the new Section 627.736(5)(a)5 requiring "a notice," ***before*** any appellate court decision mentioned any required notice, ***before*** the Florida Office of Insurance Regulation issued its "Informational Memorandum" concerning approval of "a notice," and ***before*** this Court issued any decisions construing the pre-2012 version of the PIP statute:

10/1/2007	The Florida Motor Vehicle No-Fault Law (including the PIP statute) was automatically repealed by a "sunset" provision. *See,* Ch. 2003-411, §19, Laws of Fla. (2003).
1/1/2008	Effective date of a new version of the Florida Motor Vehicle No-Fault Law. *See,* Ch. 2007-324, §8, Laws of Fla. (2007). Among other things, Section 627.736(5) was amended to include a new reimbursement limitation methodology based on a "schedule of maximum charges" which was governed by various terms and conditions in Section 627.736(5)(a)2-5.
5/18/2011	*Kingsway Amigo Insurance Company v. Ocean Health, Inc.,* 63 So.3d 63, 67 (Fla. 4th DCA 2011) held that Section 627.736 "allows an insurer to **choose between** two different payment calculation methodology options" and "anticipates that an insurer will make a **choice**." (Emph. added).
2/6/2012	State Farm submits its proposed new insurance policy form 9810A to the Florida Office of Insurance Regulation (R 208, 217-264). The "declarations page" is defined as being a

component part of the insurance policy (R 219) but was not included as part of policy form 9810A submitted to the agency (R 208, 217-264).

3/9/2012 The Florida Legislature passed CS/CS/HB 119 (2021). Among other things, Section 10 of this Bill proposes to create a new Section 627.736(5)(a)5, which would require PIP insurance policies to include "**a notice** at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges...." (www.flsenate.gov/Session/Bill/2012/119/?Tab=BillHistory). Notably, this "notice" provision did not appear in any previous versions of HB 119.

3/12/2012 *DCI MRI, Inc. v. Geico Indem. Co.,* 79 So.3d 840, 842 (Fla. 4th DCA 2012) held that "[s]imply indicating that the insurer would pay in accordance with the [PIP] law 'as amended,' is insufficient to place the insured **on notice** of its intent to pay less than 80% of reasonable expenses incurred as stated in the policy." (Emph. added). Prior appellate decisions concerning the PIP statute's schedule of maximum charges did not mention a "notice" requirement.

5/4/2012 The Florida Office of Insurance Regulation issued Informational Memorandum OIR-12-02M to "assist insurers with the filings necessary to implement the notice requirement in [proposed] Section 627.736(5)(a)5., Florida Statutes, resulting from the passage of House Bill 119" which included "a new statutory requirement that insurers provide **a notice** of the schedule of medical charges or 'fee schedule' to insureds if the insurer is limiting reimbursement."

The memorandum instructed insurers that "The Office will commit to review **filings submitted for this purpose** on an expedited basis provided that the insurer has **only** submitted **one endorsement** in the filing and that **one** endorsement **only** contains language to implement the notice requirement. **All form filings are subject to the standard form review process of Section 627.410, Florida Statutes.**" (R 266; emph. added).

7/1/2012 Effective date of the new Section 627.736(5)(a)5, which requires "a notice" in the insurance policy.

10/5/2012 The Florida Office of Insurance Regulation approved State Farm's new insurance policy form 9810A, without any indication of whether the form was approved for purposes of Section 627.736(5)(a)5, as opposed to the "standard form review process of Section 627.410" referenced in Informational Memorandum OIR-12-02M (R 47, 208, 217-264, 266).

5/4/2012 Chapter 2012-197, Laws of Fla. (2012) (Committee Substitute for Committee Substitute for House Bill No. 119) was approved by the Governor.

7/3/2013 *Geico Gen. Ins. Co. v. Virtual Imaging Services, Inc.,*141 So.3d 147 (Fla. 2013) –

- Approved the Fourth District's decisions in *Kingsway* and *DCI MRI. Virtual,* 141 So.3d at 150.

- Rejected Geico's argument that there are not two methodologies for determining reasonableness. *Id.* at 156.

- Held that "there *are* two different methodologies for calculating reimbursements to satisfy the PIP statute's reasonable medical expenses coverage mandate." *Id.* at 156.

- Held that PIP insurers have "a **choice** in dealing with their insureds as to whether to limit reimbursements based on the Medicare fee schedules **or** whether to continue to determine the reasonableness of provider changes for necessary medical services rendered to a PIP insured based on the factors enumerated in [former] section 627.736(5)(a)1 [now (5)(a)]." *Virtual,* 141 So.3d at 157 (emph. added).

- Dissent by Justice Canady observed that "the view adopted by the majority ... rest[s] on the interpretive fallacy **that §627.736(5)(a)1 and §627.736(5)(a)2, Florida Statutes (2008), respectively established mutually exclusive payment methodologies**." *Virtual*, 141 So.3d at 160 (emph. added).

18. The foregoing sequence of events firmly establishes that State Farm's new insurance policy form 9810A could not have been submitted to the Florida Office of Insurance Regulation for purposes of complying with any "notice" requirement, because the version of HB 119 proposing to enact the "notice" requirement of Section 627.736(5)(a)5 did not yet exist, because *DCI MRI* (holding for the first time that PIP insurers must "place the insured on notice" that they will rely on the schedule of maximum charges) had not yet been issued, and because Informational Memorandum OIR-12-02M (explaining how to submit "filings necessary to implement the notice requirement in Section 627.736(5)(a)5") had not yet been issued.

19. Moreover, State Farm's new policy form was submitted to the Florida Office of Insurance Regulation about 17 months before this Court issued its decision in *Virtual.* So, it is also clear that when State Farm submitted that policy form, it was not trying to comply with any decisions issued by this Court concerning the schedule of maximum charges.

D. The parties' competing motions for summary judgment are strictly governed by a limited set of stipulated facts

20. In its Opinion, it also appears that this Court has overlooked or misapprehended the stipulated undisputed facts that control this lawsuit.

21. The parties' competing motions for summary judgment in this case were strictly governed by a "Stipulated and Agreed Case Management Order" (R 170-174), which required the parties to file a stipulation containing "all facts and evidence on which the parties [would] rely in support of their respective motions for summary judgment" and that "no party [could] rely on additional facts or evidence not contained in or attached to the fact stipulation" (R 172).

22. Thereafter, the parties filed a joint "Stipulation of Fact Related to Cross-Motions for Summary Judgment" (R 207-370). According to that stipulation:

> 6. The document attached hereto as "Exhibit 2" [R 265-267] is a true, correct, and authentic copy of Informational Memorandum OIR-12-02M issued by the Florida Office of Insurance Regulation ("FOIR") on or about May 4, 2012. However, Park Place MRI does not concede that State Farm's Policy Form 9810A complies with Informational Memorandum OIR-12-02M or Section 627.736(5)(a)5, Florida Statutes (2012-2015).
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> 7. State Farm filed its Policy Form 9810A with FOIR on February 6, 2012 and FOIR approved the Policy Form 9810A on October 5, 2012. However, Park Place MRI does not concede that this has the legal effect of constituting approval within the

> meaning of Section 627.736(5)(a)5, Florida Statutes (2012-2015), or that FOIR approved Policy Form 9810A for purposes of Section 627.736(5)(a)5, or that State Farm otherwise complied with Section 627.736(5)(a)5. The parties agree that the effect of the FOIR's October 5, 2012 action and the extent (if any) to which FOIR has subject matter jurisdiction or other authority are purely legal issues to be determined by the Court based solely on the facts set forth in this Stipulation and the documents referenced herein and attached hereto.

(R 208-209).

23. Importantly, the parties' stipulation does not establish that State Farm actually submitted its insurance policy form 9810A for purposes of seeking approval of "a notice" for purposes of Section 627.736(5)(a)5, or that the Florida Office of Insurance Regulation actually approved that policy form as including "a notice" required by Section 627.736(5)(a)5, or that State Farm otherwise provided such "a notice" to any of the Petitioner's 19 insured patients at the time of issuance or renewal of their respective insurance policies.

24. To the contrary, it is clear that State Farm submitted the proposed form of an expansive new insurance policy (not merely an isolated "endorsement" which "only contains language to implement the notice requirement") to the Florida Office of Insurance Regulation on February 6, 2012, without any request for approval of "a notice" required by Section 627.736(5)(a)5 (R 208, 217-264). It is also undisputed that Informational

Memorandum OIR-12-02M specifically instructed insurers that "The Office will commit to review **filings submitted for this purpose** on an expedited basis provided that the insurer has **only** submitted **one endorsement** in the filing and that **one** endorsement **only** contains language to implement the notice requirement. **All form filings are subject to the standard form review process of Section 627.410, Florida Statutes.**" (R 266; emph. added).

25. Indeed, the parties affirmatively stipulated that the Petitioner did not concede that State Farm's policy form 9810A complies with Informational Memorandum OIR-12-02M or Section 627.736(5)(a)5, or that the Florida Office of Insurance Regulation's approval of that policy form constituted approval within the meaning of Section 627.736(5)(a)5, or that the Florida Office of Insurance Regulation approved that policy form for purposes of Section 627.736(5)(a)5, or that State Farm otherwise complied with Section 627.736(5)(a)5 (R 208-209). These were disputed issues of material fact for which State Farm presented no evidence to establish any compliance with the plain text of Section 627.736(5)(a)5.

E. State Farm presented no evidence of compliance with the requirements imposed by the plain text of Section 627.736(5)(a)5

26. This Court's Opinion quotes U.S Supreme Court Justice Clarence Thomas to embrace the "cardinal canon" of statutory construction

which requires courts to "presume that a legislature says in a statute what it means and means in a statute what it says there." *Opinion*, at p. 13 (quoting *Page v. Deutsche Bank Tr. Co. Americas*, 308 So.3d 953, 958 (Fla. 2020) and *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-254 (1992)).

27. This Court also embraces the "supremacy-of-text" principle, which holds that "[t]he words of a governing text are of paramount concern, and what they convey, in their context, is what the text means." *Ham v. Portfolio Recovery Associates, LLC,* 308 So. 3d 942, 946–947 (Fla. 2020) (quoting, Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts*, 56 (2012)).

28. To be certain, the Petitioner also embraces those same principles. However, to properly apply them in this case, it is necessary to read **all** of the related provisions of the PIP statute in *pari materia*, and to give meaning to **all** of the text therein. Indeed, as explained by U.S. Supreme Court Justice Antonin Scalia, "Perhaps no interpretive fault is more common than the failure to follow the whole-text canon, which calls on the judicial interpreter to consider the entire text, in view of its structure and of the physical and logical relation of its many parts." Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts,* 167 (2012). *See also, State v. Riley*, 638 So.2d 507, 508 (Fla.1994) (subsections of the same statute "must be read in

pari materia").

29. At pages 5 and 16 of the Opinion, this Court's analysis focuses on and quotes the first sentence of Section 627.736(5)(a)5, while omitting any reference to or quotation of the remaining sentences therein. The entire text of Section 627.736(5)(a)5 states:

> 5. Effective July 1, 2012, an insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

As confirmed by Justice Scalia, the "whole-text canon" requires this Court to consider the entire text of Section 627.736(5)(a)5, which is both relevant and applicable in this case.

30. The plain text of the first sentence of Section 627.736(5)(a)5 requires (a) the insurance policy to include "a notice," (b) which must be provided "at the time of issuance or renewal," and (c) must state that "the insurer may limit payment pursuant to the schedule of charges specified in" Section 627.736(5)(a).

31. With respect to that first sentence of Section 627.736(5)(a)5, the parties stipulated and the trial court ordered that the parties' competing motions for summary judgment would be based only upon the discreet set of

facts contained in the parties' stipulation of fact (R 172). That stipulation of fact does not establish that any of the insurance policies issued to the Petitioner's 19 insured patients in this lawsuit included "a" notice, that such "a" notice was included in any of those insurance policies "at the time of issuance or renewal," or that such "a" notice stated that State Farm "may limit payment pursuant to the schedule of charges...." In other words, the undisputed facts fail to demonstrate that State Farm complied with the plain text of the first sentence of Section 627.736(5)(a)5.

32. Consistent with the "supremacy-of-text" and "whole-text" principles embraced by this Court, "significance and effect must be given to **every word**, phrase, sentence, and part of the statute if possible, and words in a statute should not be construed as mere surplusage." *See, Gulfstream Park Racing Ass'n v. Tampa Bay Downs, Inc.,* 948 So.2d 599, 606 (Fla. 2006) (emph. added). "No part of a statute**, not even a single word,** should be ignored, read out of the text, or rendered meaningless, in construing the provision." *Scherer v. Volusia County Dept. of Corr.,* 171 So. 3d 135, 139 (Fla. 1st DCA 2015) (emph. added).

33. Accordingly, as correctly explained by this Court in quoting Justice Thomas, when the Florida Legislature inserted the indefinite article "a" before the word "notice" in Section 627.736(5)(a)5, we must "presume that [the]

legislature ... says ... what it means and means ... what it says there." *Opinion*, at p. 13 (quoting *Page*, 308 So.3d at 958 and *Germain*, 503 U.S. at 253-254).

34. Although the word "a" is one of the smallest words in the English language, it does have meaning and grammatical significance. The word "a" is an indefinite article that is used to denote "singular nouns." *Schmidt v. State*, 310 So. 3d 135, 137 (Fla. 1st DCA 2021) (citing *Merriam-Webster's Collegiate Dictionary* (11th ed. 2003) ("a" is "used as a function word before singular nouns")).

35. The meaning and grammatical significance of the word "a" has even been litigated in the U.S. Supreme Court. Justice Neil Gorsuch, when speaking for the majority of the U.S. Supreme Court (including Justice Clarence Thomas), recently explained that when a statute requires one to provide "a notice," that is not the same thing as merely "providing notice":

> Start with customary usage. Normally, indefinite articles (like "a" or "an") precede countable nouns. ... While you might say "she wrote a manuscript" or "he sent three job applications," no one would say "she wrote manuscript" or "he sent job application." See The Chicago Manual of Style § 5.7, p. 227 (17th ed. 2017); see also R. Huddleston & G. Pullum, The Cambridge Grammar of the English Language § 3.1, p. 334 (2002).
>
> By contrast, *noncountable* nouns—including abstractions like "cowardice" or "fun"—"almost never take indefinite articles." The Chicago Manual of Style § 5.7, at 227; see also Huddleston, supra, § 3.1, at 334. After all, few would speak of "a cowardice"

or "three funs."

> **These customs matter because the key term before us (notice) can refer to *either* a countable object ("a notice," "three notices") *or* a noncountable abstraction ("sufficient notice," "proper notice"). Congress's decision to use the indefinite article "a" thus supplies some evidence that it used the term in the first of these senses—as a discrete, countable thing. All of which suggests that the government must issue a single statutorily compliant document to trigger the stop-time rule. If [the subject statute] had meant to endow the government with the flexibility it supposes, we would have expected the law to use "notice" in its noncountable sense. A statute like that would have said the stop-time rule applies after the government provides "notice" (or perhaps "sufficient notice") of the mandated information—indicating an indifference about whether notice should come all at once or by installment.**

Niz-Chavez v. Garland, -- U.S. --, 141 S. Ct. 1474, 1481 (2021) (emph. added).

36. Consistent with Justice Gorsuch's above-quoted explanation, the Florida Legislature chose to use the "countable" form of the word "notice" in Section 627.736(5)(a)5, and thereby required insurance policies to include "a notice" in the form of "a discrete countable thing," instead of a "noncountable abstraction" giving insurance companies "flexibility" to merely provide "mandated information" to its insured in whatever format or medium selected by the insurance companies.

37. Indeed, the PIP statute is replete with provisions which expressly require that "a notice" be provided as opposed to merely providing notice in

the form of a "noncountable abstraction." *See,* §627.736(5)(c) and (5)(c)3 (requiring health care providers to submit "to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant"); §627.736(14) ("an insurer shall provide a notice to the insured or to a person for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed" concerning fraud violations); §627.736(16) ("A notice ... required or authorized under ss. 627.730-627.7405 may be transmitted electronically"). In sharp contrast, Section 627.736(4)(c) merely requires insureds to provide a "noncountable" or "flexible" form of "notice of an accident that is potentially covered by personal injury protection benefits," which can be provided orally by a telephone call to the insurance company.

38. Many other statutes governing the business of insurance also require "a notice" in the "countable" sense of the word. *See, e.g.,* §627.162(4), Fla. Stat. (requiring insurer to mail "a notice of default to the insured"); §627.4133(8)(c), Fla. Stat. (requiring "a notice of change of policy terms to the policyholder"); §627.421(1), Fla. Stat. (requiring electronic transmissions of insurance policies to "include a notice to the insured or to the person entitled to delivery of a policy of his or her right to receive the policy via United States mail rather than via electronic transmission"); §627.70152(3)(b), Fla. Stat. (claimant under a property insurance policy "must

serve a notice of intent to initiate litigation"); §627.712(2)(c), Fla. Stat. (requiring insurer to "provide a notice to the mortgageholder or lienholder indicating the policyholder has elected coverage that does not cover wind").

39. Case law discusses insurance policies that include "a notice" within them. *See, e.g. Jefferson Ins. Co. v. Fischer*, 166 So. 2d 129, 130 (Fla. 1964) (insurance policy included a "Special Notice" explaining that the policy does not apply unless named insured is operating the automobile outside a military reservation); *Nieves v. N. River Ins. Co.,* 49 So. 3d 810, 812 (Fla. 4th DCA 2010) (insurance policy contained "an endorsement entitled 'Important Notice,' which pertains to excess UM/UIM coverage"); *Sterling v. Ohio Cas. Ins. Co.,* 936 So. 2d 43, 45 (Fla. 2d DCA 2006) (insurance policy was issued with a form entitled "An Important Notice to Our Commercial Automobile Policyholders Regarding Changes to Your Uninsured Motorist Coverage").

40. Case law confirms that State Farm has issued other insurance policies that included "a notice." *See, e.g., State Farm Fire & Cas. Co. v. Ward*, 2021 WL 2981594, *3 (D. Mont. July 15, 2021) (State Farm's insurance policy contained a section titled "Important Notice" concerning changes to the policy); *Allen v. State Farm Fire & Cas. Co.*, 59 F.Supp.2d 1217, 1220 (S.D. Ala. 1999) (State Farm issued an endorsement form entitled "Important Notice ... Concerning Your Hurricane Deductibles" and highlighted the addition of the

new hurricane deductible endorsement to the policy). In this case, however, State Farm did not present any evidence that policy form 9810A includes such "a notice" or that such "a notice" was provided to any of the Petitioner's 19 insured patients.

41. The contents of State Farm policy form 9810A states that the insurance policy includes "the most recently issued Declarations Page" (R 219), without any explanation of how often it issues declaration pages. Notably, State Farm did not include **any** declarations page forms in its submission to the Florida Office of Insurance Regulation (R 208, 216-264). However, in several **other** PIP cases (decided **after** the trial court's August 2016 summary judgment order in this lawsuit),[4] State Farm actually presented evidence establishing that it had sent its insured a policy declarations page that included an "Important Notice" stating:

> IMPORTANT NOTICE: Under No-Fault Coverage, the only medical expenses we will pay are reasonable medical expenses that are payable under the Florida Motor Vehicle No-Fault Law. The most we will pay for such reasonable medical expenses is 80% of the "schedule of maximum charges" found in the Florida Motor Vehicle No-Fault Law and in the Limits section of the Florida Car Policy's No-Fault Coverage.

See, e.g., James A. Voglino, M.D., P.A. a.a.o. Francisco Aguila v. State Farm

[4] The trial court's nonfinal summary judgment order was entered on August 18, 2016 (R 1163-1164), and the final summary judgment was entered on September 6, 2016 (R 1165-1166).

Mut. Auto. Ins. Co., 25 Fla. L. Weekly Supp. 817a (Miami-Dade County Ct. Nov. 9, 2017); *Gary Spanier, D.C., P.A. a.a.o. Thomas Osa v. State Farm Mut. Auto. Ins. Co.,* 25 Fla. L. Weekly Supp. 831b (Broward County Ct. Oct. 24, 2017). In this case, however, State Farm did **not** present such evidence for any of the Petitioner's 19 insured patients or for any other insureds.

42. Instead of presenting any evidence of "a notice" or a declarations page purporting to include such "a notice," State Farm voluntarily opted to enter into, and be bound by, a written stipulation of the relevant enumerated set of facts that would govern the outcome of this lawsuit[5] (R 170-175, 207-370). Both State Farm and this Court are bound by and strictly limited to that stipulated set of facts. *See, e.g., Godshalk v. City of Winter Park*, 95 So.2d 9, 10 (Fla. 1957) (in declaratory suit, where in reliance upon stipulation of the parties as to issues, no testimony was offered upon other issues, on appeal the Supreme Court was bound to consider only those issues which were placed before the trial court); *Knespler v. State*, 314 So.3d 287, 291 (Fla. 3d DCA 2020), *rev. den.*, 2020 WL 4524679 (Fla. Aug. 5, 2020) (district court of appeal was bound by parties' stipulation concerning various facts); *Landmark Am. Ins. Co. v. Pin-Pon Corp.,* 267 So. 3d 411, 413 (Fla. 4th DCA 2019) (trial

[5] As part of that same stipulation, the Petitioner was required to (and did) to voluntarily dismiss the class action allegations of its counterclaim (R 171).

court was bound to factual stipulation made by insured and mistake of law in interpretation of insurance policy was not good cause to withdraw from stipulation).

43. Even if State Farm had presented any evidence that the Petitioners' 19 insured patients received the same declarations page with the same "Important Notice" that State Farm placed into evidence in cases like *Voglino* and *Spanier,* that presentation would still be insufficient to carry the day in this particular lawsuit. The document that State Farm filed with the Florida Office of Insurance Regulation as policy form 9810A does not include that declarations page form or the "Important Notice" quoted in those cases (R 208, 217-264), and there is no stipulation or evidence that the Florida Office of Insurance Regulation ever approved that form as passing muster as "a notice" required by Section 627.736(5)(a)5.

44. Although the "supremacy-of-text" principle and the plain text of Section 627.736(5)(a)5 requires "a" notice, this Court's discussion and analysis of that requirement, overlooks or misapprehends the Legislature's use of the indefinite article "a" preceding the word "notice," and concludes that Section 627.736(5)(a)5 merely "requires that an insurer provide notice of its election to use the schedule of maximum charges." Opinion at p. 5. *See also,* Opinion at p. 16-17 ("if the policy contains notice").

45. In addition to not including "a" notice, the insurance policy form in this record (R 208, 217-264) never once states that State Farm "may limit payment pursuant to the schedule of charges specified in" Section 627.736(5)(a), which is what "a notice" complying with Section 627.736(5)(a)5 must state under the "supremacy-of-text" principle. Instead of telling insureds that State Farm "may limit payment ***pursuant to*** the schedule of charges" as required by the plain text of Section 627.736(5)(a)5 or that State Farm "may limit reimbursement ***to*** 80 percent of the ... schedule of maximum charges" as stated in the plain text of Section 627.736(5)(a)1, State Farm's insurance policy states, "***in no event will we pay more than*** 80% of the ... 'schedule of maximum charges'" (R 232). In other words, State Farm does not ever promise to pay the precise amount fixed "pursuant to" the schedule of maximum charges, but instead promises to never pay "more than" that amount. This plain text means that State Farm reserves the right to pay less than the schedule of maximum charges--at its whim.

46. For example, assume that an employment contract states the employer may limit the employee's reimbursements for work-related mileage charges "to" the standard mileage rate approved by the IRS for the year 2022, that means the employer is agreeing to pay the employee at least 58.5 cents per mile. *See,* "IRS issues standard mileage rates for 2022," IR-2021-251

(Dec. 17, 2021) (https://www.irs.gov/newsroom/irs-issues-standard-mileage-rates-for-2022). In contrast, if that contract stated that the employer will "in no event pay more than" the standard mileage rate approved by the IRS for the year 2022, that means that the employer is reserving the right to pay less than 58.5 cents per mile. The same situation is presented in this case.

47. Thus, in the trial court, State Farm did not meet its burden as the party seeking summary judgment to establish by undisputed facts that it complied with any of the three requirements of the first sentence of Section 627.736(5)(a)5. There is **no evidence** that any of the 19 insured patients' insurance policies included "a notice," **no evidence** that such "a notice" was provided "at the time of issuance or renewal," and **no evidence** that such "a notice" stated "that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph."

48. The second sentence of Section 627.736(5)(a)5 states that "A policy form approved by the office satisfies this requirement." The parties' stipulation of fact and the Florida Office of Insurance Regulation's Informational Memorandum OIR-12-02M confirm that State Farm did not present undisputed facts to obtain a summary judgment establishing this requirement was satisfied as a matter of law. State Farm submitted the policy form before the notice requirement was ever identified in any case law or in

any version of CS/CS/HB 119, and before that Informational Memorandum was issued. Absent clairvoyance or the ability to predict the future or the possession of inside information (none of which is established by this record), State Farm could not have been seeking approval of "a notice" and there is no evidence that State Farm actually did seek approval of "a notice." Further, the Informational Memorandum instructed insurers that "The Office will commit to review filings submitted for this purpose on an expedited basis provided that the insurer has only submitted one endorsement in the filing and that one endorsement only contains language to implement the notice requirement. All form filings are subject to the standard form review process of Section 627.410, Florida Statutes." (R 266). Because State Farm submitted an expansive policy form (not "one" endorsement "only" containing a notice) without requesting approval of "a notice" for purposes of Section 627.736(5)(a)5, and because the Florida Office of Insurance Regulation did not specifically state that it was approving the policy form for purposes of Section 627.736(5)(a)5 (as opposed to the standard form review process of Section 627.410), State Farm failed to present any undisputed facts that could support a summary judgment holding as a matter of law that it complied with the second sentence of Section 627.736(5)(a)5.

49. The third sentence of Section 627.736(5)(a)5 states, "If a

provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted." This third sentence has no bearing on the issue of whether State Farm's policy includes "a notice," but is important in this case because it identifies the only time that a PIP insurer who has elected the schedule of maximum charges can lawfully limit reimbursement to any amount that is less than the amount fixed pursuant to the schedule of maximum charges. Nowhere else in the various terms and conditions of (5)(a)1-5 that govern the "schedule of maximum" limitation of reimbursement methodology charges does the Legislature identify any other situation where the PIP insurer is authorized to pay less than the amount fixed pursuant to the schedule of maximum charges. If the Legislature had intended to allow PIP insurers to pay less than the amount fixed pursuant to the schedule of maximum charges, the third sentence of Section 627.736(5)(a)5 is rendered meaningless surplusage in a manner that eschews the "supremacy-of-text" and "whole-text" principles. Scalia & Garner, *Reading Law,* at 167 ("no interpretive fault is more common than the failure to follow the whole-text canon, which calls on the judicial interpreter to consider the entire text, in view of its structure and of the physical and logical relation of its many parts"). *See also*, *Gulfstream,* 948 So.2d at 606 (significance and effect must be given to "every word" of the

statute); *Scherer,* 171 So.3d at 139 ("not even a single word" of the statute should be ignored).

50. In sum, under the limited set of stipulated undisputed facts that control the outcome of this particular case, there is no evidence (undisputed or otherwise) demonstrating, as a matter of law, that State Farm is entitled to a summary judgment declaring that it complied with any of the requirements imposed by the plain text of Section 627.736(5)(a)5 with respect to the Petitioner's 19 PIP claims. The Second District, therefore, erred in reversing the trial court's judgment as to those 19 PIP claims.

F. The plain text of the PIP statute confirms that the "schedule of maximum charges" limitation of reimbursement methodology establishes a "floor" and not a "ceiling"

51. At page 17 of its Opinion, this Court concludes that "a limitation based on a schedule of maximum charges establishes a ceiling but not a floor," and based on that conclusion, the Court answered its "rephrased" version of the certified question in the negative. However, in reaching this conclusion, the Court has overlooked or misapprehended the plain text of the PIP statute. As a result, the Court's conclusion conflicts with the "supremacy-of-text" principle that is invoked by the Court's Opinion and by many other decisions of this Court.

52. At page 5 of the Opinion, this Court correctly states that

"[p]rovisions governing the application of the schedule of maximum charges are detailed in subsection (5)(a)2.-5." The plain text of these "governing" provisions confirm that the schedule of maximum charges of (5)(a)1 imposes a fixed minimum amount of reimbursement.

53. The pertinent provisions contained in Section 627.736(5)(a)1 through 5 state:

> (5) ... (a) ... 1. The insurer may limit reimbursement **to** 80 percent of the following schedule of maximum charges ....
>
> . . . . .
>
> 2. **For purposes of subparagraph 1.,** the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the service year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies to services, supplies, or care rendered during that service year, notwithstanding any subsequent change made to the fee schedule or payment limitation, ***except*** **that** ***it may not be less*** **than the allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.** For purposes of this subparagraph, the term "service year" means the period from March 1 through the end of February of the following year.
>
> . . . . .
>
> 5. ... ***If*** a provider submits a charge for an amount ***less*** than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

§627.736(5)(a)1, 2 and 5 (emph. added).

54. In summary, the plain text of subsection (5)(a)1 states that insurers may limit reimbursement "to" 80% of the amount set by the "schedule

of maximum charges." The plain text of subsection (5)(a)2 states the PIP insurer must pay the amount set by the schedule of maximum charges "except" that it cannot be less than the allowable amount fixed by the 2007 Medicare Part B fee schedules for services covered by Medicare Part B. In other words, the PIP insurer must pay the amount fixed by (5)(a)1 or the amount fixed by (5)(a)2, whichever amount is higher. Then, (5)(a)5 identifies the only event when the PIP insurer is allowed to pay less than the amount fixed by (5)(a)1, which is when the insured's health care provider submits a charge for an amount that is less than the amount payable under (5)(a)1.

55. All of these provisions can only mean one thing—a PIP insurer who lawfully elects the schedule of maximum charges reimbursement methodology by issuing an "insurance policy [that] includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges" must pay the amount fixed by the schedule of maximum charges, except when (5)(a)2 requires a higher amount of reimbursement or when (5)(a)5 allows the PIP insurer to pay "the amount of the charge submitted" by the health care provider. Nowhere in the plain text of the PIP statute does it ever state or even suggest that a PIP insurer who elects to limit reimbursement to the schedule of maximum charges can ever pay less in any other situation. *See, Nationwide Mut. Fire Ins. Co. v. AFO Imaging, Inc.*, 71

So. 3d 134, 137 (Fla. 2d DCA 2011) (the 2008 versions of Section 627.736(5)(a)(2) and (3), now (5)(a)1 and 2, are "to be utilized in computing the **minimum** amount the Insurance Companies were statutorily allowed to remit") (emph. added).

56. If the plain text of subsections (5)(a)1, 2 and 5 is not clear enough, the Florida Legislature has confirmed that it adopted the schedule of maximum charges as a set of fixed reimbursement amounts in order to reduce litigation over the "reasonable amount" that was engendered under the fact-specific method currently found in Section 627.736(5)(a). *See Florida Motor Vehicle No-Fault Law,* Report No. 2006-102, p. 96-97 (Fla. Sen. Comm. on Banking & Fin. Nov. 2005) ("fee schedule would ... reduce litigation over the reasonableness of medical fees") (http://archive.flsenate.gov/data/Publications/2006/Senate/reports/interim_reports/pdf/2006-102bilong.pdf); *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.,* 90 So.3d 321, 323 (Fla. 3d DCA 2012) (the 2008 fee schedule amendments to the PIP statute "sought to address the enormous costs and inefficiencies of the law prior to amendment").

57. An insurance company is aided by electing the schedule of maximum charges as its payment methodology in two important ways. First, the insurer is no longer is required to engage in a cumbersome fact-

dependent exercise to determine the amount of a reasonable charge, and then be subjected to litigation over what is reasonable. Paying the fixed amount established pursuant to the schedule of maximum charges automatically satisfies the statutory mandate to pay reasonable expenses. Interpreting the schedule of maximum *charges* as a "cap" or "ceiling" while allowing the insurer to pay whatever amount it deems reasonable eliminates the certainty given to insurers, insureds, and health care providers, and will surely result in more litigation. Second, by limiting reimbursement "to" the fixed amount established pursuant to the schedule of maximum charges, the insurer usually pays less than it would for the same medical service before enactment of the schedule of maximum charges.[6] The trade-off contemplated by the Legislature was that PIP insurers can limit reimbursement pursuant to the schedule of maximum charges, and health care providers will know in advance what they can bill and how much they will be paid. Construing a PIP insurer's ability to limit reimbursement "to" the schedule of maximum charges as establishing a "ceiling" and not a "floor,"

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[6] *See, e.g., Geico Indem. Co. v. Physicians Group, LLC*, 47 So.3d 354, 356 (Fla. 2d DCA 2010) (PIP insurer improperly relied on Medicare fee schedules to pay merely $1,122.86 for a $10,800 surgery); *Allstate Fire & Cas. Ins. Co. v. Stand–Up MRI,* 188 So.3d 1, 3 (Fla. 1st DCA 2015) (fact-dependent method "apparently results in higher reimbursements" than fee schedule method).

transforms the schedule of maximum ***charges*** into a schedule of maximum ***reimbursements.***

G. The two methods are mutually exclusive

58. At page 14 of its Opinion, this Court concludes, "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."

59. In reaching this conclusion, it appears that this Court has overlooked or misapprehended portions of this Court's previous decision in *Virtual*. In that decision, this Court held the use of the word "may" in former subsection (5)(a), now renumbered as (5)(a)1, was "clearly permissive" and gave insurers "a choice" between using the new schedule of maximum charges method "or" to continue using the original fact-dependent method. *Virtual*, 141 So.3d at 156-157.[7] This Court also held that the schedule of maximum charges "provided an alternative, permissive way" to satisfy the

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[7] In *Virtual*, this Court held, "we conclude that the 2008 amendments were clearly permissive and offered insurers **a choice** in dealing with their insureds as to whether to limit reimbursements based on the Medicare fee schedules **or** whether to continue to determine the reasonableness of provider charges for necessary medical services rendered to a PIP insured based on the factors enumerated in section 627.736(5)(a)1." *Virtual*, 141 So.3d at 156-157. In simplified form, this sentence clearly boils down to "a choice" between one method "or" the other method.

reasonable medical expenses coverage mandate. *Id.* at 156. Based on the "alternative" and "permissive" nature of the new schedule of maximum charges method, this Court also held "the insurer must clearly and unambiguously elect the permissive payment methodology in order to rely on it." *Id.* at 158.

60. The definition of "choice" is "the act of choosing : the act of picking or deciding between two or more possibilities." *See*, https://www.merriam-webster.com/dictionary/choice. The definition of "elect" is "to make a selection of" or "to choose." *See*, https://www.merriam-webster.com/dictionary/elect. The definition of "or" is "a function word to indicate an alternative." *See,* https://www.merriam-webster.com/dictionary/or. The definition of "alternative" is "offering or expressing a choice." *See,* https://www.merriam-webster.com/dictionary/alternative. Thus, the common meaning of the words "choice," "elect," "or," and "alternative," as used by this Court in *Virtual*, all clearly manifest the existence of a "mutually exclusive" selection process.

61. In his dissent of the majority's decision in *Virtual*, Justice Canady stated that "the view adopted by the majority ... rest[s] on the interpretive fallacy that §627.736(5)(a)1 and §627.736(5)(a)2, Florida Statutes (2008), respectively established **mutually exclusive** payment methodologies." *Virtual*, 141 So.3d at 160 (emph. added). Justice Polston joined in that

dissent. While Justices Canady and Polston described the majority's holding as resting on a "fallacy," they clearly agreed that the majority's decision could only be interpreted as concluding the two methods are "mutually exclusive."

62. The Second District below obviously agreed with the observation of Justices Canady and Polston that the majority's decision in *Virtual* was premised on the two methods being "mutually exclusive." *See, State Farm Mut. Auto. Ins. Co. v. MRI Associates of Tampa, Inc.,* 252 So. 3d 773, 778 (Fla. 2d DCA 2018) (concluding that "there are no longer two mutually exclusive methodologies").

63. The other district courts of appeal are also operating under that same understanding. *See, Northwest Center for Integrative Med. & Rehab., Inc. v. State Farm Mut. Ins. Co.,* 214 So.3d 679, 680 and 682 (Fla. 4th DCA 2017), *rev. den.,* 2017 WL 3883668, (Fla. Sept. 6, 2017) (a PIP insurer "may elect to calculate medical reimbursements in one of two ways"); *Green v. State Farm Mut. Ins. Co.,* 225 So.3d 229, 230 (Fla. 4th DCA 2017) (a PIP insurer "may elect one of two methods"). *See also, Allstate Fire & Cas. Ins. v. Stand-Up MRI of Tallahassee, P.A.,* 188 So.3d 1, 2-3 (Fla. 1st DCA 2015) (the fact-dependent method "is the default methodology for calculating PIP reimbursements"); *United Auto. Ins. Co. v. ISOT Med. Ctr. Corp.,* -- So.3d --, 2021 WL 5226341, n. 1 (Fla. 3d DCA Nov. 10, 2021) (Under the 2012 version

of the PIP statute there "are two different methodologies permitted under the statute for calculating reimbursements to satisfy the PIP mandate").

64. Similarly, in *Progressive Select Ins. Co. v. Florida Hospital Medical Center*, 260 So.3d 219, 224 (Fla. 2018), this Court unanimously held that PIP insurers cannot apply the schedule of maximum charges to the portion of a medical bill that the insured patient alone is obligated to pay. This, too, is consistent with the premise that the two payment calculation methodologies must be "mutually exclusive."

65. Nothing in the plain text of the former 2008-2011 version of the PIP statute or the current 2012-2021 version of the PIP statute states that the two methods can be conjoined. Nothing in the 2012 amendments to the PIP statute altered the "alternative" and "different" nature of the two methods as described by the majority's decision in *Virtual*, or the observation of Justices Canady and Polston in their dissent in *Virtual* that the majority's decision was based on the premise that the two methods are "mutually exclusive." Any conclusion that such an alteration occurred requires one to overlook or render meaningless the extensive terms and conditions of (5)(a)2 through 5 which solely "govern" the schedule of maximum charges method of (5)(a)1. Those governing provisions serve no purpose and are emasculated if PIP insurers can adopt policy language which purports to give them unbridled discretion to

pay any PIP claim by picking-and-choosing among any elements of either-or-both methods at the same time, as State Farm's insurance policy form 9810A purports to do when it states that State Farm will consider "one or more" of the seven factors listed in its "reasonable charge" definition (R 221).

H. Conclusion

66. It is respectfully submitted that the Second District and this Court should not reverse the trial court on the basis of arguments that were not presented to the trial court and that were not raised by State Farm in its appeal as a basis to reverse the trial court. Under the tipsy coachman doctrine, appellate courts should look for ways to affirm the result reached by the trial court, not to reverse the trial court on the basis of arguments raised *sua sponte* for the first time in the appellate court's decision.

67. Assuming arguendo that it is preserved, the cornerstone of this Court's analysis is that State Farm's insurance policy satisfies the requirements of Section 627.736(5)(a)5. However, under the "supremacy-of-text" and "whole-text" canons of statutory interpretation, as well as the limited set of stipulated facts to which the parties and this Court are bound, there is simply no evidence (undisputed or otherwise) establishing as a matter of law that State Farm is entitled to a summary judgment declaring that it complied with the first and second sentences of Section 627.736(5)(a)5 with respect to

the Petitioner's 19 PIP claims in this lawsuit. Because State Farm failed to meet its burden, the result reached by the trial court is correct and its judgment should be affirmed, at least with respect to those 19 claims.

68. Beyond the 19 PIP claims at issue in this particular lawsuit, State Farm's policy language presents an untenable situation that leaves insureds, their health care providers, and the courts with no way to objectively predict, determine, or enforce the precise amount that health care provider can charge and collect, that State Farm must pay, and that the insured patients must pay, for medical expenses incurred by those insured patients.

69. If State Farm's unique policy language is approved by this Court, then State Farm (and other insurers who decide to adopt that same policy language) will have the unmitigated ability to sell illusory PIP insurance coverage, based on a hollow promise to pay an unpredictable amount of PIP benefits, which is obviously contrary to the Legislature's intent when it adopted a schedule of maximum charges generating fixed reimbursement amounts. To the extent that State Farm and other PIP insurers do not pay the precise amount fixed "pursuant to" the schedule of maximum charges, there will be more litigation and the insured patients will be subjected to balance billing by their short-paid health care providers. *See,* § 627.736(5)(a)4, Fla. Stat. ("If an insurer limits payment as authorized by subparagraph 1., the person providing

such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits."); §817.234(7)(a), Fla. Stat. (it is "insurance fraud" and a felony if a health care provider does not seek to collect the insured patient's portion of the total medical bill).

70. Instead of giving meaning to the plain text of all provisions that "govern" the schedule of maximum charges reimbursement limitation methodology as required by the "supremacy-of-text" principle, the Second District and this Court have overlooked the plain text of (5)(a)2-5 and have awarded a summary judgment to State Farm despite its failure to present any evidence (much less undisputed evidence) that it provided "a notice" that complied with any of the several requirements imposed by the plain text of (5)(a)5. Accordingly, regardless of whether PIP insurers are now lawfully authorized by the 2012 version of the PIP statute to simultaneously adopt both methods in their insurance polices, this Court should grant rehearing and hold that the trial court reached the correct result by denying State Farm's motion for summary judgment, at least as to the 19 PIP claims at issue in this particular case, due to the lack of undisputed facts to sustain State Farm's motion for summary judgment.

71. If this Court grants rehearing and affirms the trial court's final judgment as to the Petitioner's 19 PIP claims, the Petitioner will be the prevailing party. If so, the Court should also grant the Petitioner's motion for appellate attorneys' fees pursuant to Sections 627.736(8) and 627.428, Florida Statutes.

72. Alternatively, if rehearing is denied, the Petitioner requests clarification. State Farm's policy language is extremely unique, and is not used by other PIP insurers doing business in Florida. Accordingly, this Court should at least clarify its Opinion to confirm that a PIP insurer that has elected only one method in its insurance policy is only authorized to use that one method, unless and until it adopts appropriate language that simultaneously adopts both methods in a manner which satisfies the requirements imposed by the plain text of Section 627.736(5)(a)5.

73. In this regard, the Court should also clarify the extent, if any, that the Second District's decision is being affirmed. At page 18, the Court's Opinion states, "we approve the ***result*** reached by the Second District." (Emph. added). In its decision below, the Second District held that "an insurer may not disclaim the fact-dependent calculation" described in Section 627.736(5)(a). *State Farm*, 252 So.3d at 778. It is unclear as to whether that holding is part of the "result" being affirmed by this Court's Opinion. As

explained in Point (e) of the Petitioner's initial brief and reply brief, the Petitioner contends the Second District misapprehended the distinction between the reasonable medical expenses "mandate" and the fact-dependent reasonable amount "method." Clearly, nothing prohibits a PIP insurer from opting to exclusively elect one method in lieu of the other method, as long as the PIP insurer agrees to comply with the PIP statute's reasonable medical expenses mandate. Therefore, this Court should clarify that it is not approving this portion of the Second District's decision.

WHEREFORE, the Petitioner respectfully requests this Honorable Court to grant rehearing or clarification, to affirm the trial court's decision, and to grant the Petitioner's motion for appellate attorneys' fees.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy hereof was **electronically filed** with the Clerk of the Court, and **electronically served** on the following persons on this 23rd day of December, 2021:

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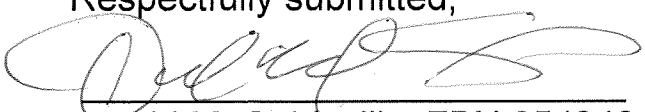

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