In the Florida Supreme Court

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

Petitioner,

VS.

Fla. S. Ct. Case No. SC18-1390

STATE FARM MUTUAL AUTO. INS. CO.,

Fla. 2d DCA Case No. 2D16-4036

Respondent.

PETITIONER'S NOTICE OF SUPPLEMENTAL AUTHORITY CONCERNING PETITIONER'S MOTION FOR REHEARING OR CLARIFICATION, AND STATE FARM'S RESPONSE

Pursuant to Florida Rule of Appellate Procedure 9.225, the Petitioner, MRI Associates of Tampa, Inc., doing business as Park Place MRI, provides the following supplemental authority concerning Petitioner's Motion for Rehearing or Clarification, and State Farm's Response to Petitioner's Motion for Rehearing or Clarification ("State Farm's Response"), and states:

1. New Hampshire Indem. Co. v. Gray, 177 So. 3d 56, 59 (Fla. 1st DCA 2015) (attached as "Exhibit A"), is pertinent and relevant to State Farm's contention that Petitioner's motion for rehearing cannot present new arguments to address errors on issues raised for the first time in the Court's opinion. See, State Farm's Response at p. 6 and 9.

- 2. *Michael A. Marks, P.A. v. Geico Gen. Ins. Co.,* 4D21-469, Slip. Op., -- So.3d (Fla. 4th DCA Jan. 12, 2022) (attached as "**Exhibit B**"), is pertinent and relevant to the issue raised on rehearing of whether the trial court's judgment can be reversed based on arguments that State Farm never presented to the trial court. *See,* Petitioner's Motion for Rehearing or Clarification, at p. 5-9; State Farm's Response, at p. 8-12.
- 3. Priority Medical Centers, LLC, a.a.o Susan Boggiardino v. Allstate Ins. Co., 319 So.3d 724, 727 (Fla. 3d DCA 2021) (attached as "Exhibit C"),¹ is pertinent and relevant to the issue raised on rehearing regarding whether the schedule of maximum charges method establishes a "floor" or a "ceiling." See, Petitioner's Motion for Rehearing or Clarification, at p. 31-33; State Farm's Response, at p. 9-10.

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 1344 day of JANUARY, 20 22:

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¹ Please note, the *Priority Medical* decision has a repeated scrivener's error, where Section 627.736(5)(a)2, Florida Statutes is erroneously cited as "(5)(a)22."

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KeyCite Yellow Flag - Negative Treatment
Distinguished by Security National Insurance Co. v. Gonzalez, Fla.App.
2 Dist., March 26, 2021

177 So.3d 56 District Court of Appeal of Florida, First District.

NEW HAMPSHIRE INDEMNITY COMPANY, Appellant, v.

John GRAY, Damil Belizaire & Daline Belizaire, jointly & severally, Appellees.

No. 1D14-3348. | Oct. 8, 2015.

Synopsis

Background: Motorist who was involved in motor vehicle collision brought personal injury action against insured and, after receiving a jury verdict, judgment, and award of taxable costs in his favor, motorist moved to enter final judgment for costs awarded and to join insurer. The Circuit Court, Duval County, W. Gregg McCaulie, J., granted motorist's motion. Insurer appealed.

Holdings: The District Court of Appeal, Thomas, J., held that:

- [1] judgment contained sufficient findings to support joinder;
- [2] the Circuit Court did not abuse its discretion by not dismissing joinder motion for allegedly untimely service; and
- [3] insured's policy covered taxable litigation costs.

Affirmed; conflict certified.

Procedural Posture(s): On Appeal.

West Headnotes (6)

[1] Appeal and Error As to Judgment, or

Modification or Vacation of Judgment

Automobile insurer failed to preserve for appeal its argument that judgment on taxable costs award in personal injury action did not contain sufficient findings to support trial court's joinder of insurer, where alleged defect necessarily first appeared on face of judgment, and insurer did not file motion for rehearing to alert trial court to alleged defect.

[2] Appeal and Error As to Judgment, or Modification or Vacation of Judgment

When errors appear for the first time in a judgment, the party harmed by the error must assert its grounds in a motion for rehearing to allow the trial court an opportunity to rectify the error, in order to preserve argument for appeal.

[3] Insurance—Costs and Attorney Fees

Trial court's judgment on taxable costs award in motorist's personal injury action against insured contained sufficient findings to support joinder of automobile insurer; parties did not dispute that motorist obtained verdict against insured and that insured was an insured under policy, both parties relied on diametrically opposed interpretations of same policy provision in support of positions on joinder, and, by granting joinder motion, it was apparent that court was persuaded by authority on which motorist relied.

West's F.S.A. § 627.4136(4).

[4] Insurance—Costs and Attorney Fees

Trial court did not abuse its discretion by not dismissing motorist's motion to join automobile

: Works



insurer in judgment on taxable costs award in his personal injury action against insured, despite contention that motorist failed to timely serve insurer via certified mail; even though motorist did not serve motion directly on insurer at time he first filed motion, motorist moved to join insurer before judgment on costs was entered, insurer received copy of motion before hearing, insurer did not seek continuance and filed opposition memorandum, and insurer suffered no prejudice from allegedly not receiving certified mail copy of motion before hearing.

West's F.S.A. § 627.4136(4).

[5] Judgment—Costs and fees

A judgment on the merits of a suit is not final for purposes of determining the collateral issues of attorney's fees and litigation costs until those issues are resolved.

[6] Insurance Defense Costs, Supplementary
Payments, and Related Expenses
Insurance Attorney fees and costs; interest

Automobile insurance policy stating insurer would pay reasonable litigation expenses incurred at its "request" covered taxable litigation costs, which exceeded by ten times insured's liability limits, incurred after insurer elected to litigate motorist's personal injury action against insured; choosing to litigate was no different than requesting to litigate based on insurer's sole right to settle or litigate claims, cloaking insurer with immunity from paying costs resulting from insurer's choice would abuse insurer's right not to be named as defendant, and insured did not purchase policy intending to be subject to cost judgment well in excess of his policy limits solely because insurer elected to exercise right to litigate. West's F.S.A. § 627.4136(1).

4 Cases that cite this headnote

Attorneys and Law Firms

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Brandon G. Cathey and Stephanie M. Miles of Swope, Rodante P.A., Tampa, for Appellee John Gray.

Opinion

THOMAS, J.

Appellant, New Hampshire Indemnity Company (NHIC), appeals a final judgment for costs imposed jointly and severally with its insured, Damil Belizaire. NHIC raises both procedural and substantive arguments against being joined in this judgment, contending: 1) NHIC was improperly joined because Appellee failed to *58 comply with the statutory service provision found within section 627.4136(4), Florida Statutes; 2) the court failed to "articulate any basis" for adding NHIC to the judgment or making any findings that the policy covered Appellee's taxable costs; and 3) the policy does not provide such coverage, rendering the judgment "substantively improper." As explained below, we reject each of these arguments and affirm.

Factual Background

Mr. Belizaire was involved in a motor vehicle collision resulting in a catastrophic injury to Appellee, John Gray, who in turn sued Belizaire for damages. NHIC provided a defense to Belizaire under the subject insurance policy and the matter went to trial, resulting in a jury verdict of \$2.3 million in damages, in Appellee's favor.

The trial court entered a final judgment against Belizaire, reserving jurisdiction to award costs. Appellee then moved to tax costs against Belizaire, serving the motion on his attorneys, who represented him at the cost hearing. The trial court granted the motion in December 2013, and awarded costs of more than \$127,000. Approximately one week later, Appellee filed a motion asking the court to enter a final judgment for the taxable costs awarded and

to join NHIC in the judgment. Appellee served the motion, not on NHIC, but on Belizaire's NHIC-retained attorneys. Ten days later, Appellee filed another motion to tax costs related to litigation that ensued after Belizaire objected to aspects of Appellee's prior cost motion. This, too, he served on Belizaire's attorneys.

In June 2014, NHIC, through independent counsel, filed a "Memorandum in Response and Opposition" to Appellee's motion. NHIC asserted that Appellee failed to comply with section 627.4136(4), Florida Statutes, by not serving NHIC with the joinder motion by certified mail. NHIC also argued that it could not be joined as a party because it was not responsible for Appellee's costs under the policy's terms.

Appellee filed a "Supplemental Certificate of Service" dated June 26, 2014 (the same day NHIC filed its memorandum in opposition to joinder), indicating that a copy of Appellee's motion was furnished by email to the attorneys who filed the opposition memorandum, and by certified mail to "AIG Insurance." Appellee filed a copy of this supplemental certificate in the trial court on September 18, 2014. The court held a hearing on the matter four days later at which counsel for NHIC, Belizaire, and Appellee appeared. NHIC argued against joinder on the same grounds asserted in its memorandum in opposition.

AIG is the company listed on the cover page of the policy at issue and is apparently NHIC's parent company.

Appellee's counsel expressed her appreciation for NHIC's memorandum, because it alerted her to the procedural defect and allowed her time to rectify it, which she asserted was achieved by filing a copy of the motion and a supplemental certificate of service via certified mail before the hearing. NHIC's counsel indicated that he had not received either document and asserted that it was insufficient to serve a motion on a Thursday before a Monday hearing. Appellee responded that the statute does not provide when a joinder motion must be served, only how, and that the carrier was represented by counsel and had been for the entirety of the litigation. The court took the matter under advisement and ultimately entered the judgment on appeal that adjudicated *59 NHIC jointly and severally liable for costs in excess of \$135,000.

I. NHIC's Procedural Challenges

NHIC asserts two procedural grounds against the trial court's judgment: 1) NHIC was improperly joined in the judgment, because Appellee failed to comply with the statutory service provision found within section 627.4136(4), Florida Statutes; and 2) the court erred by failing to "articulate any basis" for adding NHIC to the judgment and not making any finding that the policy covered Appellee's taxable costs.

[1] [2] We address the second argument first, which we find unpreserved. NHIC argues that the judgment is defective, because it does not contain sufficient findings to support the court's joinder of NHIC. Even if correct, any such defect necessarily first appeared on the face of the judgment itself. Because NHIC did not file a motion for rehearing to alert the court to the alleged defect, NHIC's arguments in this regard are unpreserved for appellate review. See, e.g., Pensacola Beach Pier, Inc. v. King, 66 So.3d 321, 325-26 (Fla. 1st DCA 2011) (holding, where "Appellants did not file a motion for rehearing asking the court to make a finding regarding [certain] statements," they failed to preserve the argument). See also Williamson v. Cowan, 49 So.3d 867 (Fla. 5th DCA 2010) (holding, "[b]ecause Appellant never challenged the adequacy of the findings in a motion for rehearing ... the issue was not properly preserved for appellate review."). We state once again: When errors appear for the first time in a judgment, the party harmed by the error must assert its grounds in a motion for rehearing to allow the trial court an opportunity to rectify the error.

^[3] Even if preserved, however, the judgment was not defective for failing to include the findings NHIC asserts were necessary. First, there was no dispute below that Appellee obtained a verdict against Belizaire, or that Belizaire was an insured under the policy, something NHIC acknowledged in its reply brief. Furthermore, both parties relied on diametrically opposed interpretations of the same policy provision in support of their respective positions on the substantive issue of joinder based, as discussed below, on conflicting district court opinions. Therefore, by granting Appellee's joinder motion, it is apparent that the court was persuaded by the authority on which Appellee relied.

Turning to NHIC's first procedural argument, section 627.4136(4) provides, in relevant part:

(4) At the time a judgment is entered ... a liability insurer may be

Legal Analysis

joined as a party defendant for the purposes of entering final judgment ... by the motion of any party.... A copy of the motion to join the insurer shall be served on the insurer by certified mail....

ISI In GEICO General Insurance Company v. Williams, 111 So.3d 240, 246–47 (Fla. 4th DCA 2013), the court explained that a carrier is timely added as a party at the time a final judgment for fees and costs is entered, citing Ulrich v. Eaton Vance Distributors, Inc., 764 So.2d 731, 733 (Fla. 2d DCA 2000), and section 627.4136, Florida Statutes. We agree with the analysis of the Fourth District in Williams. A judgment on the merits of a suit is not final for purposes of determining the collateral issues of attorney's fees and litigation costs until those issues are resolved.

Here, although it is undisputed that Appellee did not serve a copy of the motion directly on NHIC at the time he first filed the motion in January 2014, Appellee asserts *60 that he complied with this provision by sending a supplemental certificate in which he averred that he sent a copy of the motion via certified mail on the same day NHIC filed its memorandum in opposition to the motion. Appellee also argues that the statute requires the insurer to be joined by sending the insurer a copy of the motion via certified mail at or before the time the final judgment to which it is joined is entered, which he did. NHIC argues that Appellee's last-minute amended certificate of service of the motion never reached its attorneys before the hearing, and that there still is no evidence that the motion was actually mailed by certified mail, because the card indicating as much is not in the record.

NHIC relies on ACE American Insurance Company v. HCP IIII of Bradenton, Inc., 913 So.2d 1280 (Fla. 2d DCA 2005), in support of its position that failure to "timely" serve NHIC via certified mail is fatal to the judgment at issue. This reliance is misplaced. In that case, ACE and two other carriers tendered checks to satisfy a judgment against their insured, but the plaintiff filed a motion asserting the amounts paid were deficient and sought an order directing ACE pay the deficiency. Id. at 1281. The trial court entered such an order and the appellate court reversed, holding that "[t]he trial court had no in personam jurisdiction over ACE because it is undisputed that ACE was never served and was never a party to the suit." Id. Critically, the court explained: "Although, pursuant to section 627.4136(4), Florida Statutes (2004), a liability carrier may be joined at or before the time judgment is entered against its insured, there was no such joinder in the present case." *Id.*

In ACE, therefore, unlike here, the plaintiff made no attempt to join the carrier at or before the time the plaintiff asked the court for an order instructing the carrier to pay the alleged deficiency at issue; thus, the carrier was not a party against whom the court could issue an order to enforce the judgment. It was for that reason that the court lacked in personam jurisdiction.

Here, however, Appellee did move to join NHIC, and did so before the judgment on costs was entered. Additionally, there is no dispute that NHIC received a copy of Appellee's joinder motion before the hearing, as indicated by the fact that it retained separate counsel, who filed a memorandum in opposition to joinder. NHIC was also represented by counsel at the hearing on that motion and did not seek a continuance or otherwise indicate more time was needed to prepare a defense to the legal question of whether NHIC could properly be joined under the statute. Furthermore, the arguments made by counsel were identical to those raised in the opposition memorandum. Under these circumstances, even if NHIC did not receive the certified mail copy of the motion before the hearing, it did not suffer any prejudice as a result, and the court did not abuse its discretion by not dismissing the joinder motion and ruling on the merits.

This leaves the substantive question of whether the insurance policy at issue affords coverage for the taxable litigation costs included in the judgment at issue and, thus, whether joining NHIC in the judgment was proper.

II. NHIC's Coverage Challenge

The "Supplementary Payments" section of the policy at issue provides that, in addition to liability coverage, NHIC would "pay on behalf of an Insured funds toward the cost of a bail bond"; "[p]remiums on appeal bonds and bonds to release attachments in any lawsuit we defend"; "[i]nterest accruing after a judgment is entered in any lawsuit we defend" (with a proviso *61 that this duty ends when the carrier offers "to pay that part of the judgment that does not exceed our limit of liability"); limited funds for an insured's loss of wages or salary "because of attendance at hearings or trials at our request"; and, finally, "Other reasonable expenses incurred at our request." (Emphasis in original.) Taken together, these all fall under the category of "litigation expenses." It is the "other reasonable expenses" provision upon which both parties rely for their respective positions as to whether

NHIC can be added to a judgment for taxable costs awarded to a prevailing plaintiff and taxed to NHIC's insured defendant, with the phrase "at our expense" being the critical language at issue. The parties' mutual reliance on the same provision to reach opposite outcomes is based on the conflicting opinions of Florida Insurance Guaranty Association, Inc. v. Johnson, 654 So.2d 239 (Fla. 4th DCA 1995) (relied upon by Appellee), and Steele v. Kinsey, 801 So.2d 297 (Fla. 2d DCA 2001) (relied upon by NHIC).

In *Johnson*, Florida Insurance Guaranty Association, Inc. (FIGA), standing in the place of the insolvent insurer, contested a cost award in favor of the prevailing plaintiff as being in excess of the underlying insurance policy's limits. 654 So.2d at 239. FIGA relied on that portion of the policy defining the limits of liability coverage. *Id.* at 240. The plaintiff argued:

the 'costs' which it seeks are, in fact, *consistent* with the terms of the *existing* policy. The [plaintiff] contends that the 'costs' are covered within the 'Supplementary Payments' provision of the insolvent insured's policy, which provides, in pertinent part: '[i]n addition to our limit of liability, we will pay on behalf of a covered person ... [o]ther reasonable *expenses* incurred at our request.'

Id. (emphasis in original). The plaintiff argued that the "request" referred to in this provision "took the form of [the insurer's] election to litigate " the matter, and contended that, "having thus chosen to litigate, the taxable costs entered against the insured were, therefore, expenses covered under the terms of the policy. The award of taxable costs in this case are reasonable expenses incurred by the plaintiff, and charged to the defendant, as a result of the litigation of the action." Id. (emphasis in original).

The Fourth District agreed, holding that FIGA "made the decision to defend this action," and, because the carrier "had sole discretion regarding the decision to defend the lawsuit, it is obvious that the expenses incurred by the plaintiff in litigating the action were as a result of the insurance company's choice not to settle the action. Thus, those expenses were incurred at the insurer's request." Id.

The *Johnson* court also noted that the plaintiff argued that the policy provision at issue was unambiguous but that, if the court disagreed and it was in fact ambiguous, then long-standing Florida decisional law provided that "any uncertainty must be construed against the insurer and in favor of the insured. Thus, the 'Supplementary Payments' provisions obviously have the intent of

extending coverage and, therefore, must be construed liberally in favor of the insured. Accordingly, we affirm the trial court's judgment in this regard." 654 So.2d at 240 (citations omitted).

In Kinsey, the tortfeasor was insured under a policy that,

in common with most auto liability policies, gave the insurer exclusive control over settling or litigating any claim against the insured for damages covered by the policy. The policy also had a supplementary payments provision stating that the insurer would pay certain costs relating to litigation, e.g., bail bonds and post-judgment interest, including *62 '[o]ther reasonable expenses incurred at our request.'

801 So.2d at 298. Kinsey, the insured, was involved in an accident causing injury to Steele and, during the course of the litigation and pursuant to the offer of judgment statute, Steele offered to settle the matter for the policy's \$10,000 limit. This offer was refused. Id. at 299. At one point, Kinsey and the tortfeasor's insurer "entered into a joint stipulation and settlement agreement" pursuant to which the trial court was to decide "the insurer's liability for bad faith before adjudicating the underlying tort action. The parties' stipulation also contemplated that the trial court would decide whether [the policy] covered, by virtue of the above-quoted language from the supplementary payments provision, any section 789.79 attorney's fees and costs which she might owe Mr. Steele." Id. The trial court "concluded that the policy provided no such coverage," and Kinsey appealed. Id.

The *Kinsey* court held that "the language 'expenses incurred at our request' is clear on its face and should be applied according to its generally understood meaning," and recognized that its "resolution of this issue puts us in conflict with the Fourth District's opinion in *Johnson*." *Id.* The *Kinsey* court explained:

The common meaning of "request" is "the act of asking, or expressing a desire, for something; solicitation or petition." Webster's New World College Dictionary 1218 (4th ed.2001). The legal meaning of the word is "[a]n asking or petition. The expression of a desire to some person for something to be granted or done, particularly for the payment of a debt or performance of a contract." Black's Law Dictionary 1172 (5th ed.1979). Both of these commonly understood definitions reinforce the clear use of the

term within the context of the policy-that the insurer intended to pay for expenses that it had authorized and over which it had control, such as the selection of a service or product of known value and cost.

Id. The Kinsey court certified conflict with Johnson.

Although the Florida Supreme Court accepted jurisdiction, it later decided: "Upon reflection and further consideration, we now conclude that review was improvidently granted. Accordingly, this review proceeding is dismissed." *Steele v. Kinsey*, 840 So.2d 1023 (Fla.2003).

In an opinion issued two years later, however, the supreme court held that FIGA was bound by the terms of an insolvent insurer's supplementary payments provisions and, thus, "liable for interest on judgments entered to the same extent as [the insurer] would have been liable," even if this resulted in payments in excess of the policy's liability limits. Jones v. Fla. Ins. Guar. Ass'n, Inc., 908 So.2d 435, 454 (Fla.2005). The court explained:

Indeed, courts in Florida have assessed costs in excess of limits of liability against FIGA through supplementary payment provisions. In Johnson, the district court held FIGA responsible for court costs in excess of the underlying policy's liability limits. The court applied court costs through supplementary payment provision that obligated the insolvent insurer to pay on behalf of a covered reasonable person expenses incurred in the litigation. The district court reasoned that the insurer had decided against settling the claim and that the resulting litigation expenses were therefore a responsibility to be covered.

Id. at 454–55 (citations omitted). The court then observed:

In *Steele v. Kinsey*, the Second District reached the opposite conclusion, not on the basis that

fees and costs in excess of *63 policy limits could not be assessed against FIGA through supplementary payment provisions, but based on its conclusion that the language promising payment of expenses incurred at the insurer's request could not be reasonably interpreted to include litigation expenses.

Id. at 455 (citation omitted). The court noted in a footnote its prior acceptance of *Kinsey* and subsequent decision to discharge jurisdiction. *Id.* at n. 7.

The remainder of *Jones* addressed the issue of FIGA's responsibility for judgment interest which, the court explained, existed due to the FIGA Act's purpose "to avoid financial loss to claimants or policyholders due to the insolvency of the insurer. *See* § 631.51(1)." *Jones*, 908 So.2d at 454. The court also emphasized, however, that the insured's predicament was due to "FIGA's abdication of its statutory and contractual duties, one of which was a supplementary payment coverage obligation to pay interest on judgments entered against the insured." *Id.* at 455.

discharge its conflict jurisdiction in *Kinsey*, but as we read *Jones, Johnson* is still good law and we agree with the conclusion in that case. In our view, the court in *Kinsey* too narrowly interpreted the word "request": "The common meaning of 'request' is 'the act of asking, or *expressing a desire, for something;* solicitation or petition.' "*Kinsey,* 801 So.2d at 299 (emphasis added). The court also noted the legal definition of the word, explaining that it means "'[t]he expression of a desire to some person for something to be granted or done,....'" *Id.*

As both the *Johnson* and *Kinsey* courts acknowledge, under insurance policies such as the one here, insurers enjoy the sole right to settle or litigate claims against their insureds; therefore, choosing to litigate is no different than a request or "expressing a desire" to do so. Any such expression, or request, necessarily encompasses incurring litigation costs, which may mean not only the insurer's litigation costs, but also those incurred by the opposing party should that party prevail. It is the insurer's choice to litigate—a decision only it can make—that results in these costs being incurred; thus, "those expenses [are] incurred at the insurer's request." *Johnson*, 654 So.2d at 240.

Insurers have a statutory right not to be named as a defendant in an action brought by a person claiming damages as a result of an insured's negligence unless "such person shall first obtain a settlement or verdict against a person who is an insured ... for a cause of action which is covered by such policy." \[\ \ \ \ \ \ 627.4136(1), Fla. Stat. Insurers enjoy this right so as to avoid the prejudice likely to occur if a jury is aware of an insurance company's interest in the case. As interpreted by the court in Kinsey, however, pursuant to policy language such as that here, when an insurer opts to litigate "on behalf" of its insured defendant, it not only avoids being named as a defendant, it is also cloaked with immunity from paying the prevailing plaintiff's costs resulting from the insurer's choice to litigate. These costs are then imposed on the insured, who had no say in the decision to litigate. In our view, this is an abuse of an insurer's right under section 627.4136(1). Indeed, under the court's interpretation in Kinsey, an insurer that chooses litigation over settlement can be held liable for a prevailing plaintiff's litigation costs only if the insurer had specifically requested the plaintiff to incur those costs—an unlikely scenario, to say the least.

The Fourth District's interpretation in Johnson is much more consistent with the concern expressed by the supreme court in *64 Jones, in which it noted that the insured was in this predicament precisely because of the insurer's actions, and not the insured's actions. It is also particularly compelling when, as in this case, the taxable costs incurred exceed by ten times the insured's liability limits. Indeed, the Kinsey interpretation of this common insurance policy provision runs counter to the very purpose of buying insurance—to minimize liability exposure—and instead results in an insured actually purchasing greater financial exposure than he may have faced without insurance. This results in an absurd interpretation of the policy provision, in our view, which we must avoid. See, e.g., King v. Bray, 867 So.2d 1224 (Fla. 5th DCA 2004) ("The courts generally agree that where one interpretation of a contract would be absurd and another would be consistent with reason and

probability, the contract should be interpreted in the rational manner."). We find it difficult to conceive that an insured who purchases an automobile liability policy does so with the intent that he is granting the insurer not only the right to decide whether to litigate a claim brought against him, but also to potentially subject the insured to a cost judgment well in excess of his policy limits, solely because the insurer elected to exercise the right to litigate for the *insured's* benefit.

We note, too, that, given that the purpose of the offer of judgment statute, section 768.69, Florida Statutes, which is to discourage excessive or frivolous litigation, the *Kinsey* court's interpretation of the policy language in question undermines that statutory purpose, because it applies the adverse financial disincentives of the statute to the insured who had no choice in the matter, rather than the insurer who engaged in the meritless litigation.

Conclusion

Based on the foregoing, we AFFIRM the trial court's final judgment adjudicating NHIC jointly and severally liable with its insured for Appellee's taxable litigation costs. We also certify conflict with Steele v. Kinsey, 801 So.2d 297 (Fla. 2d DCA 2001).

AFFIRMED; CONFLICT CERTIFIED.

WETHERELL and RAY, JJ., concur.

All Citations

177 So.3d 56, 40 Fla. L. Weekly D2276

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DISTRICT COURT OF APPEAL OF THE STATE OF FLORIDA FOURTH DISTRICT

MICHAEL A. MARKS, P.A. d/b/a SOMERSET CHIROPRACTIC CENTER a/a/o PETER DEFILIPPO, Appellant,

v.

GEICO GENERAL INSURANCE COMPANY,

Appellee.

No. 4D21-469

[January 12, 2022]

Appeal from the County Court for the Fifteenth Judicial Circuit, Palm Beach County; Marni A. Bryson, Judge; L.T. Case Nos. 502020CC5014 and 502020AP83.

Douglas H. Stein of Douglas H. Stein, P.A., Coral Gables, for appellant.

Michael A. Rosenberg and Adrianna de la Cruz-Muñoz of Cole, Scott & Kissane, P.A., Plantation, for appellee.

GERBER, J.

The provider appeals from the county court's final order granting the insurer's motion to dismiss the provider's declaratory judgment action. The county court concluded dismissal was proper primarily because the provider could have filed a breach of contract action instead of a declaratory judgment action. The provider argues this conclusion was in error, because section 86.111, Florida Statutes (2020), expressly provides: "The existence of another adequate remedy does not preclude a judgment for declaratory relief."

We agree with the provider that the county court's conclusion was in error. However, we agree with the insurer that the provider did not raise this argument to the county court. The provider claims it raised this argument at the hearing on the insurer's motion to dismiss, but our review of the transcript indicates otherwise. Because the argument now raised on appeal was not raised below, we must affirm. See Sunset Harbour Condo. Ass'n v. Robbins, 914 So. 2d 925, 928 (Fla. 2005) ("As a general rule, it is not appropriate for a party to raise an issue for the first time on



appeal. ... [T]o 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.") (citations and internal quotation marks omitted).

On all other arguments which the provider has raised on appeal, we affirm without further discussion.

Affirmed.

MAY and FORST, JJ., concur.

Not final until disposition of timely filed motion for rehearing.

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319 So.3d 724 District Court of Appeal of Florida, Third District.

PRIORITY MEDICAL CENTERS, LLC (a/a/o Susan Boggiardino), Appellant,

ALLSTATE INSURANCE COMPANY, Appellee.

No. 3D20-291 | Opinion filed April 28, 2021

Synopsis

Background: Health care provider, as insured's assignee, brought action against automobile insurer seeking declaration as to its rights and obligations to personal injury protection (PIP) benefits under the Motor Vehicle No-Fault Law in connection with its treatment of insured, who had been injured in a car accident, alleging that had insurer reimbursed an MRI provider based on the lower non-facility participating price under Medicare, as opposed to the higher non-facility limiting charge, then additional benefits would have remained to satisfy a portion of insured's bills with provider. The County Miami-Dade County, Christina DiRaimondo, J., granted summary judgment in favor of insurer. Health care provider appealed, and question was certified.

[Holding:] The District Court of Appeal, Hendon, J., held that automobile insurer applied the appropriate reimbursement schedule at the higher non-facility limiting charge over the lower non-facility participating price.

Affirmed.

Procedural Posture(s): On Appeal; Motion for Declaratory Judgment; Motion for Summary Judgment.

West Headnotes (6)

[1] Appeal and Error→Statutory or legislative law Appeal and Error→De novo review

An appellate court reviews de novo a grant of summary judgment, as well as issues of statutory interpretation.

1 Cases that cite this headnote

[2] Statutes—Plain Language; Plain, Ordinary, or Common Meaning

The plain meaning of the statute is always the starting point in statutory interpretation.

1 Cases that cite this headnote

[3] Statutes—Purpose and intent; determination thereof

Statutes Plain language; plain, ordinary, common, or literal meaning

If the meaning of the statute is clear then an appellate court's task goes no further than applying the plain language of the statute; however, if the language is unclear or ambiguous, then the court applies rules of statutory construction to discern legislative intent.

[4] Statutes Legislative History

Examining the history of the legislation is a helpful tool in determining legislative intent.

[5] Statutes Presumptions

When the legislature amends a statute by omitting words, the general rule of construction is to presume that the legislature intended the statute to have a different meaning from that

accorded it before the amendment.

1 Cases that cite this headnote

[6] Insurance Amounts payable in general

Automobile insurer properly applied the higher non-facility limiting charge, rather than the lower non-facility participating price, when paying MRI provider for treating its insured in connection with injuries she sustained in motor vehicle accident, pursuant to Motor Vehicle No-Fault Law provision governing payment of personal injury protection (PIP) benefits, since non-facility limiting charge was the highest reimbursement allowable under the applicable Medicare fee schedule for reimbursement of PIP claims. Fla. Stat. Ann. § 627.736(5)(a)22.

1 Cases that cite this headnote

An Appeal from the County Court for Miami-Dade County, Christina Marie DiRaimondo, Judge. Lower Tribunal No. 19-8413 CC

Attorneys and Law Firms

Phillips | Tadros, P.A., and Mac S. Phillips (Fort Lauderdale), for appellant.

Shutts & Bowen LLP, and Daniel E. Nordby (Tallahassee) and Garrett A. Tozier (Tampa), for appellee.

Before HENDON, LOBREE and BOKOR, JJ.

Opinion

HENDON, J.

**1 *725 Priority Medical Centers, LLC ("Priority Medical") appeals from a final summary judgment in favor of Allstate Insurance Company ("Allstate") in which the trial court certified the following question as one of great public importance:

WHETHER "ALLOWABLE AMOUNT UNDER THE APPLICABLE SCHEDULE OF MEDICARE PART B FOR 2007 FOR MEDICAL SERVICES, SUPPLIES, AND CARE SUBJECT TO MEDICARE PART B[,]" REFERS TO THE NON-FACILITY PARTICIPATING PRICE OR THE NON-FACILITY LIMITING CHARGE.

We have jurisdiction. <u>See</u> Art. V, § 3(b)(4), Fla. Const. We answer the certified question by holding that the proper reimbursement rate for the MRI procedure at issue is the higher 2007 non-facility limiting charge, not the lower 2007 non-facility participating price.

Facts

There is no dispute as to the underling facts, to which the parties stipulated and which the trial court recited in the final judgment:

Specifically, the parties stipulated that Susan Boggiardino was insured under an automobile insurance policy issued by Allstate that was in full force and effect when she was injured in a car accident on or about May 18, 2016. Plaintiff treated Ms. Boggiardino for her accident-related injuries and, as part of that treatment, referred her Stand Up MRI of Fort Lauderdale ("SUMRIFL") magnetic resonance imaging of her lumbar spine. Both providers (Plaintiff and SUMRIFL) submitted their bills directly to Allstate under assignments of benefits. Allstate, having elected the schedule of maximum charges paid payment methodology, SUMRIFL the sum of \$1,246.46. amount represents two hundred percent of the non-facility limiting charge under Medicare Part B for CPT 72148 for calendar year 2007. Thereafter, Allstate exhausted benefits on or about August 9, 2016. After Allstate exhausted Plaintiff benefits, submitted additional bills for

payment. Allstate denied those bills because benefits were exhausted. Plaintiff, claiming that Allstate should have paid SUMRIFL the sum of \$1,141.92 based on the lower non-facility participating price as opposed to the higher non-facility limiting charge. commenced the instant case for declaratory relief and asserted that if Allstate paid SUMRIFL pursuant to the lower non-facility price, then additional benefits (\$105.54) would have remained to satisfy a portion of Plaintiff's bills.

Priority Medical filed an action for declaratory relief to determine its rights and obligations pursuant to the Florida Motor Vehicle No-Fault Law (the "No-Fault Law"), sections 627.730 — 627.7405, Florida Statutes (2016), regarding the meaning of the phrase, "allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B" as it is used in section 627.736(5)(a)22. In a lengthy opinion analyzing the relevant statutes, the trial court determined that Allstate's reimbursement calculation was correct and entered summary judgment in Allstate's favor on Priority Medical's declaratory action and certified to this court the question of great public importance noted above.

*726 Standard of review

**2 [I]We review de novo a grant of summary judgment, Volusia Cnty. v. Aberdeen at Ormond Beach, L.P., 760 So. 2d 126 (Fla. 2000), as well as issues of statutory interpretation, Hardee Cnty. v. FINR II, Inc., 221 So. 3d 1162, 1165 (Fla. 2017).

Discussion

^[2] [3] [4] The Florida Supreme Court has explained that the no-fault statutes are to be liberally construed in order to implement the legislative purpose of providing broad PIP coverage for Florida motorists. Progressive Select Ins. Co. v. Florida Hosp. Med. Ctr., 236 So. 3d 1183, 1187 (Fla. 5th DCA 2018), aff'd Progressive Select Ins. Co. v.

Florida Hosp. Med. Ctr., 260 So. 3d 219 (Fla. 2018); Nunez v. Geico Gen. Ins. Co., 117 So. 3d 388, 395 (Fla. 2013) (citing Fla. Med. & Injury Ctr., Inc. v. Progressive Express Ins. Co., 29 So. 3d 329, 341 (Fla. 5th DCA 2010)); Blish v. Atlanta Cas. Co., 736 So. 2d 1151, 1155 (Fla. 1999). In matters of statutory construction, Florida courts have repeatedly recognized that legislative intent is the guiding polestar. Jimenez v. State, 246 So. 3d 219, 227 (Fla. 2018); Sch. Bd. of Palm Beach Cnty. v. Survivors Charter Schs., Inc., 3 So. 3d 1220, 1232 (Fla. 2009). "The plain meaning of the statute is always the starting point in statutory interpretation." GTC, Inc. v. Edgar, 967 So. 2d 781, 785 (Fla. 2007). "[I]f the meaning of the statute is clear then this Court's task goes no further than applying the plain language of the statute." Id. "However, if the language is unclear or ambiguous, then the Court applies rules of statutory construction to discern legislative intent." Polite v. State, 973 So. 2d 1107, 1111 (Fla. 2007). Thus, "examining the history of the legislation is a helpful tool in determining legislative intent." Raymond James Fin. Servs., Inc. v. Phillips, 126 So.3d 186, 192 (Fla. 2013).

ISIBEFORE 2012, the PIP statute expressly referenced the Medicare Part B for 2007 "participating physician" fee schedule. In 2012, the Florida Legislature amended the PIP statute to remove the phrase "participating physician" from section 627.736(5)(a)22. and replaced it with "applicable schedule." The relevant statute now reads:

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.

Section 627.736(5)(a)22., Florida Statutes (2016) (emphasis added). When the legislature amends a statute by omitting words, the general rule of construction is to presume that the legislature intended the statute to have a different meaning from that accorded it before the amendment.

Aetna Cas. & Sur. Co. v. Buck, 594 So. 2d 280, 283 (Fla. 1992) (citing Capella v. City of Gainesville, 377 So. 2d 658 (Fla.1979)).

**3 ^[6]With that in mind, there are two available Medicare Part B Fee Schedule reimbursement possibilities for the MRI procedure at issue: the non-facility participating price or the non-facility limiting *727 charge. The record on appeal indicates that the Centers for Medicare & Medicaid Services search tool provides the following amounts:

- 200% of the non-facility participating price for CPT code 72148 in **2016** in Broward County is \$464.18.
- 200% of the non-facility participating price for CPT 72148 in 2007 in Broward County is \$1,140.92.
- 200% of the non-facility limiting charge for CPT 72148 in **2007** in Broward County is \$1,246.46.

(Emphasis added).

Allstate's policy elected to use the schedule of maximum charges or fee schedules for reimbursement of PIP claims section 627.736(5)(a)22., referenced above. The Florida PIP statute instructs insurers that they may limit reimbursement in accord with the terms of the statute, but that reimbursement may not be less than what is allowable under the 2007 Medicare fee schedule, i.e., the "applicable schedule." Thus, when an insurer calculates the reimbursement, it must first compare the amount for the Medicare fee schedule in effect at the time services were rendered, in this case 2016, with the applicable schedule for 2007, and then pay the higher of the two amounts. For the 2016 medical charges at issue in this Allstate compared the 2016 "non-facility participating price" to both the 2007 "non-facility participating price" and the 2007 "non-facility limiting charge," and paid based on the 2007 "non-facility limiting charge" because it was the highest allowable amount.

On June 14, 2016, Allstate paid \$1,246.46 to Priority Medical, which is 200% of the non-facility limiting charge in 2007 for Broward County. Priority Medical argues that for the MRI procedure at issue, 200 percent of the allowable amount under the "participating physician" fee schedule of Medicare Part B is \$464.18 for 2016 and \$1,140.92 for 2007. Priority Medical argues that the plain language of the statute required Allstate to compare the \$464.18 with the \$1,140.92 and to pay the higher of the two. Priority Medical relies on Millennium Diagnostic Imaging Center., Inc. v. Security National Insurance Co., 882 So. 2d 1027, 1029-30 (Fla. 3d DCA 2004), and Advanced Diagnostics Testing v. Allstate Insurance Co., 888 So. 2d 663 -64 (Fla. 3d DCA 2004) in which this Court held that the amount of PIP benefits payable to MRI providers is based on the participating physicians fee schedule and not on the limiting charge. We note that these cases relied on the pre-2012 amendment language "participating physician," which the Legislature removed and replaced with "applicable schedule." These cases are not applicable to the current PIP/Medicare statutory reimbursement language at issue here. Under the current version of the PIP statute, and giving effect to the 2012 legislative amendment, the highest reimbursement allowable fee schedule of Medicare Part B is the non-facility limiting charge for 2007, which was the amount on which Allstate was required to base its reimbursement to Priority Medical for the MRI procedure at issue.

On de novo review of the record, legislative history, and statutory language at issue, we conclude that Priority Medical's conclusion is incorrect based on the post-2012 amended PIP language. We answer the certified question by holding that the proper reimbursement rate is the higher 2007 non-facility limiting charge, not the lower 2007 non-facility participating price, and affirm the final judgment below.

**4 Affirmed.

All Citations

319 So.3d 724, 2021 WL 1652024, 46 Fla. L. Weekly D978

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