United Automobile Insurance Co. vs Marisol Rodriguez

GOOD MORNING AND WELCOME TO THE ORAL ARGUMENT CALENDAR AT THE FLORIDA SUPREME COURT. IT IS MY UNDERSTANDING THAT THE PETITIONERS ARE GOING TO SPLIT THEIR TIME, EIGHT AND EIGHT, SO LET'S BE CAREFUL TO OBSERVE THAT, AND SO THERE WILL BE FOUR MINUTES FOR REBUTTAL, TWO BY EACH PETITIONER, SO, MR. STARK, ARE YOU READY TO PROCEED?

MAY IT PLEASE THE COURT. MY NAME IS JIM CLARKE. I WILL BE GOING FIRST. MR. STARK WILL, THEN, BE FOLLOWING ME. I REPRESENT -- THIS AROSE OUT OF THE COUNTY COURT LEVEL AGAINST STATE FARM, MERELY FOR THE REASON THAT STATE FARM DID NOT HAVE, WITHIN ITS PHYSICAL POSSESSION, 30 DAYS AFTER A MEDICAL BILL WAS SUBMITTED UNDER A PERSONAL INJURY PROTECTION BENEFIT, A REPORT FROM AN EXAMINER, SAYING THAT THE MEDICAL BILL WAS UNREASON UNREASONABLE, UNNECESSARY, UNRELATED TO THE ACCIDENT. STATE FARM, THREE MONTHS AFTER THE ACCIDENT HAD OCCURRED, HAD RECEIVED WHAT WE COMMONLY CALL BULK BILLING FROM A HEALTH CLINIC, CALLED McL HEALTH CLINICS. IT WAS A BILL IN THE AMOUNT OF $486. IT ENCOMPASSED MANY MEDICAL TREATMENTS, MANY, I BELIEVE IN EXCESS OF 50 MEDICAL TREATMENTS. STATE FARM, IMMEDIATELY UPON RECEIVING THIS INFORMATION, TOOK STEPS TO TRY TO INVESTIGATE THE CLAIM THAT WAS BEING MADE UPON THEM, AND 28 DAYS AFTER THEY HAD RECEIVED THE BILL WERE SUCCESSFUL IN CONTACTING A DOCTOR, SETTING UP AN APPOINTMENT, PROVIDING THAT DOCTOR WITH ALL OF THE MEDICAL BILLS AND REPORTS THAT THEY HAD REGARDING THIS PARTICULAR CLAIMANT AND HAD THE DOCTOR REPORT ON THAT PARTICULAR INFORMATION. THE DOCTOR, BEING A PHYSICIAN, I IMAGINE, TOOK HIS TIME IN REPORTING HIS RESULTS OF HIS EXAMINATION TO STATE FARM.

MR. CLARK, THERE IS A 30-DAY REQUIREMENT IN THE STATUTE, CORRECT?

THERE IS A 30-DAY REQUIREMENT IN THE STATUTE FOR ALL COVERED EXPENSES, UNDER THE STATUTE. THE FACT THAT IT IS THE PETITIONER'S POSITION IN THIS PARTICULAR CASE, BUT THE FACT THAT AN EXPENSE IS SUBMIT UNDER PIP, DOESN'T MAKE IT A PRESUMPTIVE THAT THE EXPENSE IS NECESSARILY OR REASONABLE RELATED TO AN ACCIDENT. THAT THERE HAS TO BE SOME EXAMINATION OF THE EXPENSE, TO DETERMINE WHETHER OR NOT THIS IS A PROPER EXPENSE, UNDER THE STATUTE.

IS IT A STATUTORY SCHEME THAT THE INSURANCE COMPANY IS TO DO THAT, WITHIN 30 DAYS, OR THAT THERE IS TO BE THE SANCTION OF INTEREST?

THAT'S CORRECT. THE STATUTE PROVIDES THAT, FOR THOSE BILLS THAT ARE PAYABLE, PURSUANT TO THE STATUTE, FOR WHICH PAYMENT IS NOT PAID, WITHIN 30 DAYS, THERE IS -- ACTUALLY THERE ARE THREE DIFFERENT REMEDIES PROVIDED TO AN INSURED, SHOULD THAT PROPERLY-SUBMITTED BILL, WHICH IS PAYABLE UNDER THE STATUTE, THAT IS IT IS REASONABLE, NECESSARY AND RELATED TO THE CAR ACCIDENT --

BUT DO YOU HAVE TO DO ANYTHING, WHEN THAT 30-DAY PERIOD IS UP? DO YOU HAVE TO MAKE ANY KIND OF NOTIFICATION TO THE INSURED, AS TO WHETHER OR NOT YOU ARE GOING TO PAY SOME OR ALL OR NONE OF THE CLAIMED EXPENSES?

THERE IS NO REQUIREMENT IN THE STATUTE THAT INSURANCE CARRIER ACTUALLY, ON THE 30th

DAY, DO, AS YOUR HONOR INDICATES. I THINK MOST INSURANCE CARRIERS, HOWEVER, AS A MATTER OF PRACTICE, ARE IN CONTACT WITH, USUALLY BY THE ATTORNEY AT THIS TIME, PERHAPS WITH THE INSURED DIRECTLY, IN LETTING THEM KNOW WHAT IS HAPPENING, BECAUSE BY THAT TIME, USUALLY THEY HAVE SENT OUT EITHER A REQUEST FOR SOME ADDITIONAL INFORMATION. THEY HAVE ASKED THE INSURED TO APPEAR FOR AN INDEPENDENT MEDICAL EXAMINATION. PERHAPS THEY HAVE STARTED NEGOTIATIONS WITH THE ATTORNEY OR THE INSURED. WHEN CAN YOU GET IN HERE? WHEN CAN WE TAKE A SWORN STATEMENT?

BUT YOU ARE TELLING ME, THOUGH, THAT THEY DON'T HAVE TO, AND THERE IS NO TIME PERIOD IN WHICH THEY HAVE TO NOTIFY THE INSURED ABOUT ANYTHING?

CORRECT. THE STATUTE DOESN'T REQUIRE -- THERE IS NO STATUTORY REQUIREMENT THAT THE INSURED BE NOTIFIED AT ANY PARTICULAR POINT IN TIME.

SO WHAT HAPPENS, THEN, IF SUIT IS FILED BY THE INSURED ON THE 31th DAY?

OKAY.

WHAT, THEN, HAPPENS, IN THE PIP LAWSUIT?

THEN THE INSURED HAS TO GO FORWARD AND SHOW THAT I SUBMITTED EXPENSES THAT WERE COVERED EXPENSES UNDER THE STATUTE. I MEAN THE CASE LAW IS FAIRLY CLEAR THAT THE EXPENSES, DARIUS VERSUS ALLSTATE COMES TO MIND, IMMEDIATELY, OUT OF THE FOURTH DCA, HAS TO PROVE THAT THIS IS AN EXPENSE UNDER THE STATUTE. IF THE INSURANCE COMPANY HAS NOT PAID WHAT IS DETERMINED TO AND COVERED EXPENSE, UNDER THE STATUTE, WITHIN 30 DAYS, IT WILL HAVE TO PAY INTEREST. IT WILL PROBABLY PAY ATTORNEYS FEES, BECAUSE, YOUR HONOR, ON THE 30th DAY AN ATTORNEY HAS TAKEN CHARGE AND FILED SUIT. PLUS ANOTHER REMEDY IS PROVIDED IN THE INSURANCE PART OF THE STATUTE THAT IS A VIOLATION OF THE INSURANCE CODE, FOR AN INSUROR TO MAKE A GENERAL BUSINESS PRACTICE OF NOT PAYING COVERED EXPENSES.

CAN THEY, THEN, AT THE 31 -- AFTER 31 DAYS, AND THE LAWSUIT IS FILED, CAN THEY, THEN, AT THAT POINT, JUST START THEIR INVESTIGATION AND USE THAT IN THE PIP SUIT? IS THAT CONTEMPLATED BY THE STATUTE? THAT THAT, THEN, BECOMES A LITIGATED CLAIM?

LET'S TAKE -- I THINK WHAT YOU ARE ASKING, IF THE INSURANCE CARRIER RECEIVES MEDICAL BILLS, DOES NOTHING FOR 30 DAYS, JUST PUTS THEM IN A DRAWER AND SAYS LET'S SEE WHAT HAPPENS, ON THE 31th DAY, THEY GET A LAWSUIT. CAN THEY CONDUCT -- ARE -- CAN THERE BE SOME INVESTIGATION --

IF WE DON'T ACCEPT THE WAIVER THEORY, AND UNDER YOUR THEORY, THAT THIS CAN JUST BE A REGULAR LAWSUIT, THE INSURANCE COMPANY COULD WAIT FOR THE --

THROUGH DISCOVERY, I WOULD IMAGINE THAT THE INSURANCE COMPANY ATTORNEY COULD TAKE DISCOVERY AND DECIDE WHETHER SOME OF THE BILLS WERE PAYABLE OR MAYBE NONE OF THE BILLS WERE PAYABLE, UNDER THE STATUTE, AND IN THAT SITUATION, THE INSURANCE COMPANY WOULD BE CORRECT, IN IT HAD NO OBLIGATION, UNDER THE STATUTE, TO PAY ANY OF THE BILLS.

WHAT IS THE PURPOSE OF THE STATUTE?

THE PURPOSE OF THE STATUTE, ACCORDING TO THIS COURT'S EARLY DECISION ON THE CONSTITUTIONALITY, IN THE LASKE CASE, WAS TO ENSURE THAT THE SAILIENT ECONOMIC LOSSES THAT AN INSURED OCCURS, AT THE TIME OF A CAR ACCIDENT, WHICH ARE REASONABLE, NECESSARY AND RELATED TO THAT CAR ACCIDENT, ARE PAID IN A PROMPT AND EFFICIENT

MANNER, BY THE INSURANCE COMPANY.

BUT, THEN, UNDER WHAT YOU JUST TOLD US, THAT WHOLE PURPOSE WOULD BE THWARTED. YOU COULD JUST SIT BACK, WAIT FOR A LAWSUIT, DO YOUR INVESTIGATION, AND THEN DETERMINE WHETHER OR NOT YOU ARE GOING TO MAKE ANY KIND OF CASE.

IF WE MAKE THE ASSUMPTION THAT, WHEN THOSE BILLS ARE RECEIVED BY THE INSURANCE COMPANY, THOSE WERE PRIMARILY REASONABLE AND NECESSARY RELATED BILLS, AND WHEN THE INSURANCE COMPANY TOOK THOSE PAYABLE BILLS, WHICH ARE COVERED BY THE STATUTE, AND PUT THEM IN A DRAWER, THAT INSURANCE COMPANY WAS EXPOSING ITSELF TO SOME PRETTY SUBSTANTIAL PENALTIES. IN ADDITION TO INTEREST, IN ADDITION TO ATTORNEYS FEES, IF IT DOES THAT AS A GENERAL BUSINESS PRACTICE, THERE ARE PENALTIES BY THE DEPARTMENT OF INSURANCE THAT CAN PUT THAT INSURANCE CARRIER OUT OF PLAQUETIS, IN THE STATE OF FLORIDA, OR CAN -- PRACTICE, IN THE STATE OF FLORIDA, OR CAN SUBJECT IT TO PUNITIVE DAMAGES.

BUT THAT DOESN'T HELP THIS PERSON WHO IS THERE AND HAS NEEDED THIS MEDICAL ATTENTION AND HAS SUBMITTED THESE BILLS, AND TO SAY THAT THE REMEDY IS TO JUST GO INTO COURT AND GET THEIR ATTORNEYS FEES BACK AND INTEREST, SEEMS THAT WE WOULD ALMOST ENCOURAGE INSURANCE COMPANIES TO DO WHAT YOU HAVE JUST DESCRIBED, WHICH IS TO BASICALLY DO NOTHING.

I DON'T KNOW THAT IT WOULD ENCOURAGE THEM, YOUR HONOR, BECAUSE THESE ARE PRETTY SUBSTANTIAL PENALTIES THAT THE INSURANCE COMPANY PROVIDES.

MR. CLARK, YOU SAY THAT THE STATUTE PROVIDES THOSE, AND UNDER YOUR SCENARIO, YOUR CLIENT DIDN'T GET THE BILLS -- THE ACTION WAS IN MARCH AND DIDN'T GET THE BILLS UNTIL JUNE, AND YOU REACTED RAPIDLY --

AND PAID A LOT OF BILLS.

I UNDERSTAND. BUT IF YOU HAVE GOT A 10% PROVISION IN THE STATUTE THAT, IS GOING TO BE AWARDED, EVEN IF YOU DIDN'T HAVE A STATUTE. ATTORNEYS FEES, 628, THEY ARE AWARDED, SO COULD YOU ADDRESS THAT END, THAT THE STATUTE DOESN'T, REALLY, ADD ANYTHING, MORE THAN JUST WHAT OUR BASIC FLORIDA LAW WOULD HOLD, AND I THINK THAT IS WHAT THEY ARE CONCERNED WITH.

THE 10 PERCENT INTEREST PAYMENTS, AND I ONLY HAVE A SECOND OR TWO, THE 10 PERCENT INTEREST PAYMENTS WERE PENALTY INTEREST. AT THE TIME THAT THEY WERE PASSED, JUDGMENTS ONLY ALLOWED FOR 6% ON JUDGMENTS AT THAT TIME. SO THIS WAS AN INCREASED PENALTY THAN ONE WOULD NORMALLY -- IN FACT THE INTEREST RATES HAVE GONE UP AND DOWN AND IT IS A FACT OF LIFE.

BUT DON'T YOU AGREE, THOUGH, THAT THE INTENT OF THIS STATUTE WAS IN THE ORDINARY CASE, TO SEE THAT THESE BILLS ARE PAID WITHIN 30 DAYS, UNLESS?

TO SEE THAT COVERED EXPENSES WERE PAID WITHIN 30 DAYS, UNLESS --

UNLESS. UNLESS WHAT?

UNLESS THEY WERE NOT COVERED. IF THEY WERE NOT COVERED --

ISN'T THERE AN EXPRESS PROVISION IN THE SCHEME THAT SAYS, UNLESS THE INSUROR HAS REASONABLE PROOF --

FOR COVERED EXPENSES.

THAT THERE IS SOMETHING THE MATTER.

IF IT IS A COVERED EXPENSE. IF THERE IS A REASONABLE AND NECESSARY, RELATED BILL OUT THERE, BUT THE INSURANCE COMPANY HAS PROVE, FOR INSTANCE, THAT THAT PERSON DIDN'T RESIDE IN MY HOUSEHOLD --

DID THE INSURANCE COMPANY, IN THIS CASE, HAVE REASONABLE PROOF, WITHIN THAT 30-DAY PERIOD, THAT THAT WAS A PROBLEM?

THAT IS WHAT MAKES IT HARD IN THIS CASE, YES, BECAUSE THERE WAS REASONABLE PROOF OUT THERE. A DOCTOR HAD FORMULATED HIS OPINION.

BUT MY BASIC QUESTION TO YOU WAS DON'T YOU AGREE THAT THIS STATUTORY SCHEME CONTEMPLATES THAT THESE BILLS ORDINARILY BE PAID WITHIN 30 DAYS, UNLESS THE INSURED HAS REASONABLE PROOF THAT THERE IS A PROBLEM?

THAT COVERED EXPENSES SHOULD BE PAID, AND IF -- UNLESS THERE IS REASONABLE PROOF. IF THERE IS NOT REASONABLE PROOF, AND IF COVERED EXPENSES ARE NOT PAID, THEN THERE ARE PENALTIES AVAILABLE UNDER THE STATUTE. THE STATUTE DOES NOT SAY, AS THE THIRD DISTRICT SAID, THAT AN INSURANCE COMPANY HAS TO VERIFY AND PAY A BILL WITHIN 30 DAYS. IT DOES NOT CONTAIN --

IT IS UNDISPUTED, HERE, THAT THERE WAS NO REASONABLE PROOF, WITHIN THE 30 DAYS. IS THAT CORRECT?

WELL, THERE WAS NO REASONABLE PROOF, IN THE ACTUAL HANDS OF THE INSURANCE COMPANY AT THAT TIME. THE IME HAD TAKEN PLACE. THE COMPANY HAD ACTED WITH ALACRITY, WITH PARTICULAR ATTENTION TO DO WHAT NEEDED TO BE DONE, SO THAT THE PARTICULAR BILL COULD BE PAID, AND WHEN THEY GET THEM BACK, THEY PAID MOST OF THE BILLS THAT WERE SUBMITTED. ONLY A COUPLE OF EXPENSES WERE DISALLOWED.

WE HAD BETTER GIVE MR. STARK A CHANCE.

YES. THANK YOU.

GOOD MORNING, YOUR HONORS. STEPHEN STARK, AND I THINK I WOULD LIKE TO FOLLOW UP WITH WHAT JUSTICE ANSTEAD SAID, WITH REGARD TO NO REASONABLE PROOF. THE THIRD DISTRICT SAID THAT YOU, AS A PIP INSUROR, WITH REASONABLE PROOF, CAN ONLY HAVE WITHIN 30 DAYS, TO SAY THAT A BILL IS NOT NECESSARY OR RELATED, A REPORT OF AN EXPERT, UNDER SECTION 7-A.

SET ASIDE THAT ISSUE ABOUT THERE BEING A WRITTEN REPORT OR WHATEVER FOR A MOMENT.

OKAY.

DO YOU AGREE THAT THE EXPRESS PURPOSE OF THIS STATUTORY SCHEME IS TO SEE THAT, IN THE ORDINARY CASE,, THAT THESE BILLS WILL BE PAID, WITHIN 30 DAYS?

I BELIEVE THAT'S TRUE.

THAT IS THE PURPOSE.

BUT THERE IS AN UNLESS IN THERE, IS IT NOT?

THERE IS A "UNLESS".

WHAT IS THE "UNLESS"?

THE PURPOSE OF THE STATUTE IS TO PAY THEM WITHIN 30 DAYS, AND IT IS OVERDUE, IF NOT PAID WITHIN 30 DAYS.

UNLESS WHAT?

YOU ARE NOT SUBJECT TO THE STATUTORY PENALTIES, IF, WITHIN 30 DAYS, YOU HAD REASONABLE PROOF. THAT IS A EXCEPTION TO IT BEING OVERDUE.

YOUR CASE IS WHAT CASE? IS THERE AN ISSUE ABOUT THAT OR PROOF ABOUT THAT, THAT IS WHETHER YOUR COMPANY HAD REASONABLE PROOF, WITHIN THAT 30-DAY PERIOD?

WELL, WE CERTAINLY DIDN'T HAVE A WRITTEN REPORT, WITHIN 30 DAYS. WE HAD IT -- WE RECEIVED BILLS IN OCTOBER AND DECEMBER. WE HAD IT REVIEWED, ACTUALLY, IN THE RECORD, IN NOVEMBER, BY ONE PHYSICIAN. IN JANUARY BY ANOTHER ONE, WHO LOOKED AT IT AND SAID THESE ARE THE REASONABLE AND NECESSARY CHARGES. WE PAID THAT PORTION OF THE CHARGES, WHICH WE DEEM TO BE REASONABLE AND NECESSARY.

MY QUESTION IS, IS THERE AN ISSUE IN YOUR CASE, WHETHER YOUR COMPANY HAD REASONABLE PROOF, WITHIN THE 30-DAY PERIOD -- I AM ASKING, NOW, NOT A WRITTEN REPORT, NECESSARILY.

AS IT CAME UP TO THE DISTRICT COURT OF APPEAL, AND AS IT CAME UP FROM THE RECORD BELOW, THE ANSWER IS NO. THERE WAS NO QUOTE/UNQUOTE REASONABLE PROOF, AS DEFINED ULTIMATELY BY THE THIRD DISTRICT AS BEING A REPORT, BUT THERE WAS NO REASONABLE PROOF WITHIN THE 30-DAY PERIOD. NOW, ULTIMATELY THE ISSUE WAS WHAT HAPEBBS, IF YOU DON'T HAVE THAT REASONABLE PROOF WITHIN 30 DAYS, AND I THINK THAT IS WHAT WE ARE HERE, TRYING TO DISCUSS WITH THE COURT.

YOU DON'T THINK THE LEGISLATIVE SCHEME CONTEMPLATES THAT, IF YOU DON'T HAVE REASONABLE PROOF, THAT THE BILL BE PAID?

I DON'T BELIEVE SO, AND I THINK THAT IS WHERE -- THAT IS WHERE THE DICHOTOMY IS, IN THIS WHOLE ARGUMENT, BECAUSE IF, IN FACT, THE BILLS ARE UNREASONABLE OR THE CARE IS UNNECESSARY OR IT IS NOT RELATED TO THE ACCIDENT, IT IS CLEAR THAT THE PURPOSE BEHIND THE STATE WAS TO ASSURE THE PAYMENT OF REASONABLE AND NECESSARY MEDICAL CHARGES. INDEED, IN THE LASKE CASE, WHERE THIS COURT FOUND IT CONSTITUTIONAL, IF SAID, LOOK, THIS IS A VERY NARROW, LINTED DENIAL OF ACCESS TO COURTS, AND IT IS IN THOSE CIRCUMSTANCES, WHERE WE ARE GOING TO GIVE TO THE PEOPLE THE RIGHT TO COLLECT NO-FAULT BENEFITS, FOR REASONABLE AND NECESSARY MEDICAL CHARGES, UP TO A CERTAIN POINT, REGARDLESS OF WHETHER OR NOT THEY WERE AT FAULT OR NOT AT FAULT. WE WILL RELIEVE THEM FROM LAWSUITS SEEKING PAIN AND SUFFERING DAMAGES FOR THESE MINOR AUTOMOBILE ACCIDENTS, AND IN THOSE CASES, WHERE THERE ARE MAJOR LOSSES AND THRESHOLD INJURIES, THEY, STILL, HAVE ACCESS TO THE TORT SYSTEM.

WHAT DOES YOUR POLICY PROVISION PROVIDE?

I DO NOT KNOW, YOUR HONOR. AND -- PROVIDE WITH RESPECT TO WHAT?

IT IS IN RESPECT TO WHEN YOU WILL PAY THE CLAIMS. IT IS ONE OF THESE EASY-READING POLICIES. IT IS PART OF THE RECORD, THOUGH.

I DO NOT KNOW. PRESUMABLY POLICIES PAY WITHIN A REASONABLE TIME. MOST OF THEM SAY

EITHER 30 OR 60 DAYS. I DON'T KNOW WHAT THIS ONE SAYS F THIS ONE SAID 60 DAYS, THE ANSWER IS -- IF THIS ONE SAID 60 DAYS, THE STATUTE SAYS THAT, YES, YOU SHOULD ADJUST THIS LOSS AND LOOK AT IT WITHIN THE 30-DAY PERIOD. NOW, GRANTED --

I UNDERSTAND YOU ARE ARGUING ABOUT WHAT THE PENALTY SHOULD BE, BUT THE STATUTE IS UNDISPUTED THAT THE STATUTE INTENDS TO SHIFT THE BURDEN TO THE INSURANCE COMPANY, ONCE THE CLAIM IS FILED WITH THE INSURANCE COMPANY, TO DO THIS REASONABLE INVESTIGATION. WITHIN THE 30-DAY PERIOD. DO YOU DISPUTE THAT?

I THINK THE STATUTE IS INTENDED FOR THEM TO PROMPTLY INVESTIGATE AND EVALUATE THESE CLAIMS. IF THEY DON'T PAY --

ARE YOU SAYING THAT THEY DON'T HAVE -- THAT THEY COULD DO THAT, IF IT IS BACK LOGGED, THEY CAN DO THAT WITHIN 90 OR 120 DAYS?

I AM SUGGESTING THAT THE ANSWER, IF THEY DO THAT AS A REGULAR BUSINESS PRACTICE OR IF THEY DO THAT ON A REGULAR BASIS, THEY ARE GOING TO GET SUBJECT TO INTEREST. THEY ARE GOING TO GET SUBJECT TO ATTORNEYS FEES. LET ME TALK ABOUT THE INTEREST FOR A SECOND. IT DOESN'T REQUIRE A LAWSUIT. IF, OUTSIDE THE 30 DAYS, YOU DON'T HAVE REASONABLE PROOF BUT YOU PAID ON DAY 35, THE ANSWER IS THAT CHECK IS GOING TO HAVE TO HAVE AN INTEREST COMPONENT IN IT OF 10%.

IS THAT WHAT THE INSURANCE COMPANIES REGULARLY DO?

YES. IT IS WHAT THEY REGULARLY DO. THEY PAY THE INTEREST ON THE CLAIMS, EVEN IF THEY ARE PAID AFTER THE FACT. THE PROBLEM, REALLY, COMES IN WITH RESPECT TO OFTENTIMES THEY HAVE THESE REVIEWED. THEY HAVE PEER REVIEWS. THEY HAVE OTHER PEOPLE LOOK AT THEM. I THINK THERE IS REASONABLE PROOF. YOU CAN CERTAINLY LOOK AT SCHEDULES OR MEDICARE GUIDELINES OR OTHER THINGS WITH RESPECT TO PAYMENTS. THEY PAY THAT WHICH IS REASONABLE AND NECESSARY. THIS CASE IS ABOUT PAYING THE DIFFERENCE BETWEEN WHAT THE INSURANCE COMPANY SAID WAS REASONABLE AND NECESSARY AND WHAT THE CLAIMANTS SAY WAS -- SHOULD HAVE BEEN PAID, AS THE TOTAL BILL.

YOU ARE INTO YOUR REBUTTAL.

CAN I ASK JUST ONE QUESTION. MR. STARK, WAS THERE REASONABLE PROOF, THERE, THAT THE COMPANY DID HAVE THOSE KINDS OF THINGS, ALTHOUGH THEY MAY NOT HAVE HAD A MEDICAL EXAM, THAT THEY HAD THOSE KINDS OF THINGS IN THEIR HANDS. IT IS IN THE RECORD. THAT THAT WAS THE REASONABLE PROOF. DO WE HAVE THAT?

THEY ONE OF THE ORIGINAL BILLS REVIEWED BY A PARTICULAR PHYSICIAN. THEY HAD ANOTHER SET OF BILLS REVIEWED BY ANOTHER PHYSICIAN, DR. MILLER, AND BASED UPON DR. MILLER'S REPORT, THEY PAID THAT WHICH DR. MILLER SAID WAS REASONABLE AND NECESSARY CHARGES.

THAT IS IN JANUARY, RIGHT?

JANUARY 16.

I AM ASKING, WITHIN 30 DAYS, YOU HAD THESE THINGS, AND THAT CAN BE RENABLE PROOF. DO THEY HAVE IN THIS -- CAN BE REASONABLE PROOF. DO THEY HAVE IN THIS RECORD THAT THAT CAN BE REASONABLE PROOF? DO THEY HAVE A RECORD OF THAT?

PROBABLY NOT, AS OF OCTOBER 15, ALTHOUGH THERE WAS PROBABLY A REPORT IN NOVEMBER. AS TO THE DECEMBER 17 BILL, SHE LOOKED AT THEM ON THE 17th AND THE WRITTEN REPORT WAS NOT SIGNED UNTIL THE 19th, BUT THAT WAS OUTSIDE THE 30 DAYS, JUST LIKE WITH THESE

FOLKS. AGAIN, THE ULTIMATE ANSWER IS, IF THERE IS NO REASONABLE PROOF WITHIN THAT TIME FRAME, DOES THAT MEAN THERE IS AN ASSUMPTION THAT ALL OF THOSE BILLS ARE REASONABLE AND MUST BE PAID. WE SUBMIT THAT THAT, REALLY, DOES THWART THE LEGISLATIVE INTENT. THANK YOU.

MAY IT PLEASE THE COURT. JOHN H RUIZ, AS WELL AS ALAN ALVAREZ, ON BEHALF OF THE RESPONDENTS, MARISOL RODRIGUEZ AND JUANA MARY A PEREZ. THE POLICY AND ALL POLLS IN THE STATE OF FLORIDA HAVE TO COMPLY WITH THE NO-FAULT IS A STATUTE, EVEN IF THEY SAY DIFFERENTLY.

WHAT IS THE SPECIFIC PROVISION?

UNDER 627.736-4.

I AM NOT INTERESTED IN WHAT THE STATUTE SAYS. I AM INTERESTED IN WHAT THE POLICY SAYS. ANOTHER POLICY HAS TO TRACK THE STATUTE. IT SPECIFICALLY SAYS --

IT DOES?

YES, IT DOES. IT SPECIFICALLY STATES --

THAT WE WILL PAY --

-- WITHIN 30 DAYS OF REASONABLE PROOF OF COVERED EXPENSES. THAT IS WHAT THE POLICY STATES. THAT IS WHAT THE LAW STATES, IN THE STATE OF FLORIDA. BASED UPON THAT, THIS COURT AFFIRM BOTH SUMMARY JUDGMENTS, AND JUDGE MILION, CONFIRM, IN THE TRIAL COURT BELOW. THESE CASES ARE CRYSTAL CLEAR, IN TERMS OF THE FACTS. YOU HAVE A SITUATION WHERE THE INSUREDS PROVIDE WHAT IS REQUIRED UNDER THE STATUTE, WHICH IS REASONABLE PROOF OF COVERED LOSSES AND EXPENSES. REASONABLE PROOF. THIS IS NOT A SITUATION LIKE THE IVY CASE, WHERE THERE IS A MISTAKE, IN A BILL. THIS IS REASONABLE PROOF. THE BURDEN THAT THE INSUREDS HAD, UNDER THE STATUTE, WAS MET. THIRTY DAYS WENT BY, AND THE INSURED DID NOT MEET ITS RESPONSIBILITY, UNDER THE STATUTE, WHICH IS EITHER TO PAY OR, ITSELF, HAVE OBTAINED REASONABLE PROOF, TO ESTABLISH THAT IT WAS NOT RESPONSIBLE FOR THAT PAYMENT. NOW, THE POSITION THAT IS TAKEN BY THE INSURANCE COMPANIES IN THIS CASE, IS, WELL, IF WE JUST SIT DOWN AND DO NOTHING, LEAVE THE BILLS IN OUR DRAWER, WE ARE ONLY EXPOSED TO INTEREST AND ATTORNEYS FEES.

JUSTICE SHAW, YOU HAD A QUESTION?

IF THE LEGISLATURE MEANT FOR THE STATUTE TO BE INTERPRETED IN THE FASHION THAT YOU ARE ASKING US TO INTERPRET IT, WOULDN'T IT HAVE BEEN EASY ENOUGH TO SAY THAT YOU LOSE YOUR RIGHT TO CHALLENGE THE CLAIM? AND THAT IS WHAT YOU ARE GETTING AT. AND THAT LANGUAGE IS NOT IN THE STATUTE. WE HAVE TO REDO THE STATUTE OR GO INTO INTERPRETATION, TO GET TO THAT RESULT, DO WE NOT?

NOT NECESSARILY, YOUR HONOR, AND THE REASON WHY IS THAT I THINK THAT ALL OF THE CASE LAW COMING OUT FROM THIS COURT, IT IS CLEAR THAT THE POLSTAR OF IS TO PROVIDE MEANINGFUL INTERPRETATION. THE VERY PURPOSE OF WHY THE STATUTE WAS ENACTED,, TO BEGIN WITH, IS TO PROVIDE SWIFT PAYMENT TO THESE INSUREDS, NOW, THE INSUREDS GAVE UP THE RIGHTS TO SUE ON BODILY INJURY CLAIMS. IF WE FOLLOW THE ANALYSIS OF THE INSURANCE COMP NIRTION AND LET ME GIVE YOU EXAMPLE, LET'S SAY THAT I WAS REAR-ENDED AND I GO TO THE HOSPITAL AND I INCUR MEDICAL EXPENSES. UNDER THE POSITION OF THE INSURANCE COMPANIES, UNDER A NO FAULT SCHEME, THEY CAN -- A NO-FAULT SCHEME, THEY CAN SIT BACK AND NOT HAVE TO PAY THEM, AND AT SOME POINT IN TIME, NOT RELATED TO WHEN THIS IS, THEY SAY LET'S TAKE A CRAP SHOOT AND GO IN FRONT OF A JURY AND NOT PAY

THESE REASONABLE EXPENSES.

OVER AND ABOVE WHAT THE STATUTE SEAS SAYS, THE STATUTE LAYS OUT TWO PENALTIES, THE ATTORNEYS FEES AND THE 10 PERCENT, BUT THE WAY YOU ARE INTERPRETING THE STATUTE, NOW, IT, ALSO, HAS ANOTHER PENALTY. YOU LOSE YOUR RIGHT TO CHALLENGE ANY OF THE CLAIMS CLAIM, AND THAT -- OF THE CLAIM, AND THAT IS A SERIOUS EXTRAPOLATION FROM THE TWO THING THAT IS ARE FACIALLY SET FORTH IN THE STATUTE.

NOT NECESSARILY, YOUR HONOR, AND I WILL TELL YOU Y THE LEGISLATIVE SCHEME WAS TO PROVIDE SWIFT PAYMENT N FINISHING MY ANALYSIS -- PAYMENT. IN FINISHING MY ANALYSIS, IF THIS WAS A FAULT STATE AND I WAS IN AN ACCIDENT AND I WERE TO INCUR MEDICAL EXPENSES IN A HOSPITAL, GUESS WHAT? THE INTEREST STARTS TO RUN, DAY ONE, BECAUSE MY MEDICAL BILLS ARE LIQUIDATED, SO UNDER THE ANALYSIS OF THE INSURANCE COMPANIES, THEY GET BOTH BENEFITS. THEY GET THE BENEFIT THAT WE, NOW, HAVE A NO-FAULT STATE, AND IN ADDITION TO THAT, THEY HAVE A 30-DAY GRACE PERIOD WHERE THEY DON'T HAVE TO PAY INTEREST. ON TOP OF THAT THEY DON'T WANT TO PAY THE MEDICAL BILLS. THEY CAN SAY WE WILL WAIT AND SEE WHAT HAPPENS, AND IF WE LOSE, WE WILL LOSE ATTORNEYS FEES, BUT IN THE BIG SCHEME OF THINGS --

LET ME FOLLOW-UP ON JUSTICE SHAW'S QUESTION NOW. WOULD YOU AGREE THAT THERE IS A LONG-STANDING PRINCIPLE UNDER FLORIDA LAW THAT SAYS YOU CANNOT CREATE COVERAGE BY ESTOPPEL?

YES, YOUR HONOR.

BUT IN EFFECT, IF YOU ARE SAYING THAT, EVEN THOUGH A MEDICAL BILL IS NOT COVERED, THE INSURANCE COMPANY CANNOT CONTEST IT BEING COVERED, UNLESS IT DOES SO, WITHIN 30 DAYS. THEN, IN EFFECT, TO THOSE BILLS WHICH ARE NOT COVERED, BUT ARE NOT DENIED WITHIN 30 DAYS, YOU HAVE CREATED COVERAGE, BY ESTOPPEL, HAVEN'T YOU?

NO, YOUR HONOR, AND I DON'T BELIEVE THAT THOSE ARE THE FACTS OF THIS CASE, AND I THINK THAT YOU ARE REFERRING TO THE BLOCK MARINA CASE, AND SPECIFICALLY IN THAT DAYS, THIS COURT STATED THAT A DENIAL OF COVERAGE -- WE DON'T HAVE COVERAGE DISPUTED IN THIS CASE. WE HAVE A CASE WHERE BOTH INSURANCE COMPANIES HAVE RECEIVED REASONABLE PROOF OF COVERED LOSSES AND EXPENSES. THEY ARE NOT SAYING THAT THEY HAD TO PAY THEM. THEY ARE JUST CONCEDING THAT THEY RECEIVED WHAT, UNDER THE STATUTE, IS A REQUIREMENT OF THE INSURED. REASONABLE PROOF OF COVERED LOSSES AND EXPENSES.

WHAT I AM GETTING AT IS JUDGE KLEIN'S OPINION, OUT OF THE FOURTH DISTRICT, WHICH I READ TO MEAN THAT HE INTERPRETS THE STATUTE AS BEING, SETTING UP A SITUATION WHERE, IF THE INSURANCE COMPANY DOESN'T ACT, IT HAS SPECIFIC REQUIREMENTS, WHICH ARE PAYING THE 10 PERCENT AND THE ATTORNEYS FEES, AND I BELIEVE IT IS CORRECT THAT, WHEN THIS STATUTE WAS PASSED, THERE WAS, ONE, A CONSIDERABLE QUESTION AS TO WHETHER YOU COULD RECOVER INTEREST IN TORT CLAIMS,, TO BEGIN WITH, AND WE DIDN'T DIDN'T KNOW THE ANSWER TO WHETHER YOU GOT INTEREST ON THESE MEDICAL BILLS OR NOT, OUT OF THIS COURT THERE WASN'T AN ANSWER, BUT SECONDLY, THAT THE INTEREST WAS AT 6 PERCENT. IT WAS A VERY LOW RATE, BACK IN THOSE DAYS, BUT AT ANY RATE, THE -- THAT HE SAYS THAT, YOU KNOW, THE -- IF IT IS NOT REASONABLE PROOF TO ESTABLISH, THEN THE INSURANCE COMPANY IS RESPONSIBLE FOR PAYMENT AND INTEREST, HOWEVER, THE INSURED DOES NOT HAVE RIGHT TO CONTEST PAYMENT.

YES, YOUR HONOR, AND I AM FAMILIAR WITH THE DOAN CASE, WHICH IS WHAT YOU ARE READING FROM, AND WITH ALL DUE RESPECT TO JUDGE KLEIN, I WAS INVOLVED IN THE APPEAL, IN THE THIRD DISTRICT COURT OF APPEALS. WHAT IS STATED IN THE DOANE CASE IS A MISS REPUTATION OF WHAT HAPPENED. THE THIRD DISTRICT COURT OF APPEALS DID NOT STATE THAT

INSURORS HAVE TO PAY UNREASONABLE AND UNNECESSARY MEDICAL EXPENSES. THAT IS NOT THE HOLDING OF THE CASE. THIS DECISION, IN THE DOANE CASE, BASICALLY MAKES A JUDGMENT ON WHETHER OR NOT THESE MEDICAL BILLS WERE COVERED OR NOT, AND THAT IS NOT THE BASIS. SEE, IN THE IVY CASE, THE THIRD DISTRICT COURT OF APPEALS STATED THE INSURANCE INSURANCE COMPANY DID NOT HAVE, IF YOU READ IT CAREFULLY, REALLY, THE INSURANCE COMPANY DID NOT RECEIVE REASONABLE PROOF OF COVERED LOSSES AND EXPENSES, AND THAT IS WHY IT WAS OKAY FOR THEM TO PAY WITHIN 30 DAYS OF HAVING LEARNED OF THE ERROR, WHICH, THEN, ESTABLISHED REASONABLE PROOF. THE FACTS IN THIS CASE, WHICH WOULD HAVE TO COME BACK TO, IS THAT THE INSUROR, THE INSUREDS, DID PROVIDE THE REASONABLE PROOF MANDATED BY THE STATUTE.

BUT YOU NDZ THE PRINCIPLE -- BUT YOU UNDERSTAND THE PRINCIPLE OF LAW THAT IS GOING TO COME OUT OF THIS PROCEEDING, HAS FAR MORE IMPLICATION THAN JUST THIS CASE, AND I AM CONCERNED WITH A CASE, FOR EXAMPLE, SOMEONE FALLS OFF A LADDER AT HOME. BREAKS A LEG. THEY ARE RIDING IN A VEHICLE, HEADING TO THE HOSPITAL, AND THEY HAVE A SMALL INCIDENT, DOES NOT CAUSE A FRACTURED LEG, AND THE CARRIER DOES NOT DISCOVER THAT THE FRACTURED LEG WAS DUE TO A FALL AT HOME BUT WAS LATER, THAN IS THE KIND OF THING THAT IS OUTSIDE OF THIS REASONABLE AND NECESSARY KIND OF THING THAT YOU CAN BATTLE ALL DAY. IT IS IN THE AREA OF WHERE SOMETHING SOMETHING IS NOT EVEN PART OF WHAT IS SUPPOSE -- SOMETHING THAT IS NOT EVEN PART OF WHAT IS SUPPOSED TO BE COVERED AND IS WHAT, I THINK, JUSTICE WELLS IS GETTING TO. YOU WOULD FORCE THAT TO BE A COVERED CLAIM, CORRECT, BECAUSE THE BILLS HAVE COME IN, AND A CARRIER COULD NOT, WHEN YOU SUE THEM FOR THE SETTING OF THAT FRACTURED LEG, COULD NOT CONTEST IT.

THAT IS NOT COMPLETELY ACCURATE, AND I WILL EXPLAIN WHY.

OKAY.

THE BILLS, WHEN YOU SEE THEM ON THEIR FACE, THE NEW STATUTORY SCHEME, WHICH IS IN EFFECT OCTOBER 1, 1998, REQUIRES THAT YOU SUBMIT THESE CLAIMS ON AN ACA 1500 CLAIM FORM. THAT GIVES THE INSURANCE COMPANY ALL THE INFORMATION THAT THEY NEED. IT HAS TO HAVE A DIAGNOSIS. IT HAS TO HAVE A CURRENT PROCEDURAL TERMINOLOGY CODE, WHICH GIVES THE INSURANCE COMPANY THE ABILITY TO, WITHIN THAT TIME FRAME, MAKE A DETERMINATION WHETHER OR NOT IT NEEDS TO INVESTIGATE FURTHER. SO, YES, WE ARE ASKING THIS --

WOULD A FRACTURED LEG SHOW, ON A FORM, AS BEING RELATED TO A FALL AT HOME AND NOT THE AUTOMOBILE ACCIDENT?

IF THE DOCTOR PUTS THAT THE BASIS FOR THE TREATMENT WAS AN AUTOMOBILE ACCIDENT, WHICH IS CONTEMPLATED IN THE FORM, THEN, YES, THE INSURANCE COMPANY WOULD BELIEVE THAT IT IS RELATED TO THE AUTOMOBILE ACCIDENT. BUT I CAN TELL YOU, IF SOMEBODY FALSE AT HOME, NO RIGHT PHYSICIAN IS GOING TO PUT THAT THE LEG FRACTURE RESULTED FROM A CAR ACCIDENT.

MAYBE THE PHYSICIAN DOESN'T KNOW. WHAT I AM SAYING IS THAT YOU CAN HAVE SITUATION THAT IS SHOULD BE COVERED BY HEALTH INSURANCE OR COMP INSURANCE OR OTHER THINGS THAT WERE NEVER INTENDED TO BE COVERED BY COMP, AND I THINK THAT IS WHAT JUSTICE WELLS IS GETTING TO. YOU ARE GOING TO FORCE THOSE TO BE COVERED.

NO, AND I DON'T BELIEVE SO. THERE ARE SAFEGUARDS THAT ARE IN PLACE ALREADY. THE STATUTORY SCHEME, IN PLACE RIGHT NOW, REQUIRES THAT ALL BILLS BE SUBMITTED ON THESE CLAIM FORMS. THE INSURANCE COMPANY, NOW, UNDER THE NEW SCHEME, HAS 20 DAYS TO LOOK AT THAT CLAIM FORM, AND HAS AN OPPORTUNITY TO REQUIRE ADDITIONAL INFORMATION,

WITHIN THAT TIME FRAME, TO MAKE A DETERMINATION AS TO WHETHER OR NOT IT IS COVERED. UNDER YOUR EXAMPLE, I WOULD TAKE THE POSITION THAT, IF I WERE TO PRESENT BILLS ON BEHALF OF AN INSURED, FOR THAT TYPE OF A LOSS, IT IS VERY SIMPLE. THE INSURANCE COMPANY CAN GO TO THE TRIAL JUDGE AND SAY, JUDGE, YES, WE RECEIVED BILLS, BUT THOSE BILLS WERE NOT REASONABLE PROOF OF COVERED LOSSES AND EXPENSES. THAT IS A DIFFERENT FACT SITUATION THAN WHAT WE HAVE HERE. BECAUSE ON THEIR FACE, ANY TRIAL JUDGE WILL SEE, YES, THIS IS NOT -- THIS MAY BE PROOF OF BILLS, BUT IT IS NOT REASONABLE PROOF OF BILLS THAT ARE AS A RESULT OF USE AND MAINTENANCE AFTER AUTOMOBILE. I THINK THE USE ANALYSIS, QUITE FRANKLY, IS IF YOU TAKE THE POSITION 6 OF THE INSURANCE COMPANIES, YOU -- POSITION OF THE INSURANCE COMPANIES, YOU MIGHT AS WELL THROW OUT THE NO-FAULT ALL TOGETHER. THE JUDGMENT ANNOUNCED IN LASKE, WILL BE THROWN OUT THE WINDOW. MAYBE IT IS NOT A MEIR EFFECT STATUTE, BUT THE PURPOSE OF THE STATUTE, THE WAY IT SHOULD WORK IS THE INSURED HAS A RESPONSIBILITY. UNDER THE NEW STATUTE, THE INSURED OR THE MEDICAL PROVIDER, IF THEY DO NOT PROVIDE THE INSURANCE COMPANY WITH BILLS, WITHIN 30 DAYS OF TREATMENT, THEY DON'T GET PAID.

IS THERE A FAHD LENT SET OF FACTS? IF YOU HAVE GOT A SCHEME WITH A CHIROPRACTOR OR PHYSICIAN OR SOMETHING THAT, REAL, LATER, IT IS -- THAT, REALLY, LATER IT IS DEMONSTRATED THAT IT IS A FRAUDULENT SCHEME, BUT IT ISN'T DISCOVERED UNTIL AFTER THIS CUTOFF DATE PASSES. IS THERE AN EXCEPTION FOR FRAUD LENT CLAIMS?

WELL, UNDER THE SCHEME, THERE IS NO EXCEPTION. HOWEVER, THERE ARE OTHER WAYS THAT THE INSURANCE COMPANY FIGHTS FRAUD, AND I THINK THAT IS A LEGITIMATE QUESTION AND A PROBLEM THAT A LOT OF INSURORS ARE ENCONSIDERING. HOWEVER, I BELIEVE SINCE -- ARE ENCOUNTERING. HOWEVER, SINCE JUNE OF 1995, EVERY INSURANCE COMPANY THAT WRITES OVER $10 MILLION OF INSURANCE POLICIES HAS TO HAVE A SPECIAL INVESTIGATIVE UNIT, AND THAT IS EXACTLY WHAT THEY DO. THEY INVESTIGATE THESE TYPES OF CASES. IN THE BIG SCHEME OF THINGS, WILL SOME BILLS THAT MAY BE FRAUDULENT HAVE TO BE PAID, BECAUSE THE INSURANCE COMPANIES AREN'T ABLE TO DO IT? PERHAPS.

LET ME ASK YOU THIS. UNDER THE PRACTICE IN THIS AREA, WHAT HAPPENS IS YOU SUBMIT YOUR BILLS, AND THEN, IF THE INSURANCE COMPANY DOESN'T -- IF THE INSURANCE COMPANY PACE -- PAYS, THEN THE LAWYER HAS -- WITHIN THE 30-DAY PERIOD, THEN THE LAWYER HAS NO BASIS TO FILE SUIT AND GET ATTORNEYS FEES.

THAT'S CORRECT, YOUR HONOR.

IF THE INSURANCE COMPANY DOES NOT PAY, ON THE 31th DAY, THE LAWYER STEPS IN AND FILES THE CLAIM, AND THEREFORE YOU GET -- YOU CAN GET ATTORNEYS FEES. ISN'T THAT RIGHT?

RIGHT.

SO, REALLY, THE SANCTION, THERE, IS IF THE INSURANCE COMPANY DOESN'T PAY WITHIN THE 30 DAYS, THAT IS THE EXPOSURE TO ATTORNEYS FEES. BECAUSE THAT IS WHEN -- AFTER THAT DAY, THEN, THE FERRETING OUT OF WHAT IS REASONABLE AND WHAT IS NOT REASONABLE IS GOING TO BE IN COURT. IT IS GOING TO BE -- HAVE TO PAY ATTORNEYS FEES, AND WHY ISN'T THAT THE SANCTION THAT WAS CONTEMPLATED BY THE LEGISLATURE?

TWO PROBLEMS WITH THAT ANALYSIS. NUMBER ONE, YOU GET ATTORNEYS FEES, IRRESPECTIVE OF WHETHER IT IS A NO-FAULT CLAIM OR ANY OTHER FIRST PARTY CLAIM.

YOU DON'T, IF THEY ACT WITHIN 30 DAYS.

THAT IS WHY THEY SHOULD HAVE REASONABLE PROOF OR PAY WITHIN 30 DAYS.

SO DOESN'T THE STATUTE MAKE CLEAR THAT IS, ON THE 31th DAY, YOU STEP IN AND FILE SUIT, AND YOU GET ATTORNEYS FEES?

BUT YOUR HONOR THAT IS NO DIFFERENT THAN WHAT HAPPENS IN A HOMEOWNERS CASE.

BUT IF THE POLICY PROVIDES THAT THEY HAVE GOT 60 DAYS OR SIX MONTHS TO ACT ON THE CLAIM, THEN YOU DON'T GET ATTORNEYS FEES DURING THE PROOF OF LOSS PERIOD, BY STEPPING IN AND FILING SUIT, AND THERE IS A CASE OUT OF THE FOURTH DISTRICT THAT SAYS THAT.

BUT THAT PROMOTES LITIGATION, AS OPPOSED TO WHAT IS ANNOUNCED IN LASKE, WHICH IS TO DO AWAY WITH LITIGATION, AND THE TRADE-OFF AS TO WHY THE STATUTE WAS FOUND TO BE CONSTITUTION, UNDER LASKE. UNDER THAT ANALYSIS, THE INSURANCE COMPANY WILL SIT DOWN AND TAKE A REST. THEY WILL SIT DOWN AND RECEIVE ALL OF THE BILLS. WE KNOW THAT NOT EVERYBODY IS GOING TO GO TO A LAWYER, EITHER. A LOT OF PEOPLE WILL SIT THERE AND NOT GOING TO HAVE THEIR BILLS PAID. THEY ARE NOT GOING TO GET A LAWYER, AND IF YOU TAKE THE POSITION THAT THEY ARE TAKING, UNDER THE LIMITED CIRCUMSTANCES AND FACTS OF THIS CASE, NOT THE READ HERING, IN THE BRIEFS, BY THE INSURANCE COMPANY, THE FACTS OF THIS CASE, A DECISION FROM THIS COURT, LIMITED IN SCOPE, WHERE, UNDER THE FACTS OF THIS CASE, WHERE THERE IS REASONABLE PROOF OF COVERED LOSSES AND EXPENSES, THEY CONCEDE THAT 30 DAYS GO BY. THERE ARE NO COVERAGE DEFENSES. SEE, UNDER SOME OF FRAUED EXAMPLES, THOSE MAY BE COVERAGE DEFENSES. THOSE MAY BE FAILING TO COMPLY WITH CONDITIONS PRECEDENT. FAILURE TO COMPLY WITH CONDITIONS SUBSEQUENT TO THE POLICY. THERE ARE OTHER EXAMPLES, WHICH WE CONCEDE ARE NOT WAIVED, UNDER OUR ANALYSIS. THOSE ARE, STILL, AVAILABLE DEFENSES. IN THIS CASE, ALL WE HAVE IS AN INSURANCE COMPANY HAVING RECEIVED WHAT WE KNOW FROM THE RECORD ARE MEDICAL BILLS FOR TREATMENT THAT, AT LEAST, PROVIDED -- WAS REASONABLE PROOF THAT THEY WERE COVERED LOSSES AND EXPENSES, AND IT SAT THERE AND DID NOTHING FOR 30 DAYS, AND THEY DIDN'T MEET THE REQUIREMENTS OF THE STATUTE, AND TO SIT THERE AND SAY ALL WE HAVE OR ARE EXPOSED TO IS INTEREST AND ATTORNEYS FEES, DESTROYS THE VERY BASIS OF THE NO-FAULT LAW AND OF THE LASKE CASE?

WHY SHOULD WE BE TRYING TO INTERPRET THIS STATUTE IN ANY EVENT? IT APPEARS PRETTY CLEAR ON ITS NAYS. WHY -- ON ITS FACE. WHY IS THE STATUTE NOT CLEAR? THE POINT YOU ARE ASKING US TO ARRIVE AT, ADD MIDETLY, EVEN BY YOU -- ADMITTEDLY, EVEN BY YOU, GOES PAST WHAT IS CLEAR ON THE FACE OF THE STATUTE HERE. WHY DO WE EVEN GET INTO TRYING TO INTERPRET IT? WHY SHOULDN'T WE READ IT JUST AS IT IS?

AND I THINK THAT, WHEN YOU READ IT JUST AS IT IS, IT TELLS YOU THAT COVERED LOSSES AND EXPENSES ARE DUE AND PAYABLE AS LOSS ACCRUES, UNLESS THE INSURANCE COMPANY HAS 30 DAYS TO PROVE THAT THEY ARE NOT RESPONSIBLE.

BUT IT DOESN'T SAY ANYTHING ABOUT THE INSURANCE COMPANY LOSING ITS RIGHT TO CHALLENGE.

IT SAYS THE ONLY PENALTY IS INTEREST AND ATTORNEYS FEES, BUT WHAT YOU HAVE TO DO IS LOOK AT THE SCHEME OF THE STATUTE. IF YOU DON'T LOOK AT THE SCHEME OF THE STATUTE AND, PERHAPS, IN OTHER CONTEXT, THIS MAY NOT BE THE RIGHT DECISION, BUT UNDER THE FACT OF THIS CASE AND THE CONCEPT BEHIND FLORIDA'S NO-FAULT LAW, THIS IS THE ONLY INTERPRETATION THAT CAN BE GIVEN TO THE STATUTE, IN ORDER TO MAKE SURE THAT THE STATUTE IS NOT RULED UNCONSTITUTIONAL. IF NOT, WHAT DOES THE INJURED VICTIM GET, IN EXCHANGE FOR LOSING THEIR RIGHT TO SUE? NOTHING.

IN EVERY OTHER INSTANCE, ISN'T IT CORRECT, WHERE AN INSURANCE COMPANY DOESN'T PAY, DENNIS COVERAGE, WHAT YOU GET, WHEN -- DENIES COVERAGE, WHAT YOU GET, WHEN YOU GO INTO COURT AND ENFORCE THE POLICY, IS INTEREST AND ATTORNEYS FEES?

YOU ARE CORRECT, YOUR HONOR, YES.

AND SO, IN ORDER FOR US TO READ THIS STATUTE, OR TO MAKE A DIFFERENT SANCTION FOR NO-FAULT, WE WOULD BE TREATING NO-FAULT AS DIFFERENT THAN ANY OTHER FORM OF INSURANCE.

ABSOLUTELY, AND I THINK THAT THAT IS CLEAR. THAT IS WHAT WE ARE SAYING. WE ARE NOT CONTESTING HOLDINGS INTO THE PIONEER CASE. THOSE ARE LEGITIMATE HOLDINGS BASED ON THE LAW APPLICABLE TO THOSE CASES. THOSE ARE THE TOTALLY DIFFERENT TO A SCHEME DESIGNED EXACTLY FOR A TRADE-OFF, AND IN THE TRADE-OFF, THERE HAS TO BE SOME TRADE-OFF. IT MAKES NO SENSE WHATSOEVER, IF WE HOLD THAT. I THINK THE CREDIBILITY ARGUMENT THAT I HAVE GIVEN TO THIS COURT, IF YOU LOOK AT THE NEW STATUTE, IT SPECIFICALLY STATES, UNDER SUBSECTION 5, THAT AN INSURED SHALL NOT HAVE BEEN CONSIDERED TO HAVE BEEN SERVED WITH NOTICE OF COVERED LOSS OR MEDICAL EXPENSES, DUE, UNLESS THE STATED BILLS COMPLY WITH THIS PARAGRAPH. WHAT THE INSURANCE COMPANY SUCCESSFULLY LEGITIMATED FOR IS, AS MR. CLARK STATED, WE RECEIVED BULK BILLING. WHAT THEY LEGITIMATED FOR IS WE DON'T WANT BULK BILLING. WE WANT TO HAVE THE BILLS SUBMITED IN A SPECIFIC CLAIM FORM THAT IS UNIVERSAL FOR THE WHOLE ENTIRE STATE OF FLORIDA, A BE IF IT IS NOT SUBMITED IN THAT FORM, IT CANNOT BE PAID. THE 30 DAYS DO NOT START TO RUN. IF YOU LOOK AT SOME OF THE OTHER DECISIONS FROM THE THIRD DISTRICT COURT OF APPEALS, THE ARGUMENT THAT I AM MAKING MAKES SENSE F YOU READ THE AMADORE CASE, IT MAKES SENSE THAT, THE INSURANCE COMPANY CAN PUT LANGUAGE IN THEIR POLICY THAT WILL BASICALLY GIVE GUIDANCE TO THE INSUREDS, OF WHAT REASONABLE PROOF IS, AS LONG AS IT COMPLIES WITH THE STATUTORY SCHEME. THE THIRD DISTRICT COURT OF APPEALS WAS NOT SITTING IN A VACUUM AND SAYING ANYTHING THAT COMES IN, IRRESPECTIVE OF COVERAGE OR FRAUD OR ANYTHING ELSE, HAS TO BE PAID WITHIN 30 DAYS. WE KNOW THAT, BECAUSE THE IVY CASE SAYS DIFFERENTLY.

MR. PEREZ, YOUR TIME IS UP.

THANK YOU. BASED ON THE ARGUMENTS PRESENTED, WE RESPECTFULLY REQUEST THAT THIS COURT AFFIRM THE SUMMARY JUDGMENTS IN THE CONSOLIDATED CASES. THANK YOU FOR YOUR TIME.

JUSTICE WELLS, MAY I HAVE 30 TODAY -- MAY I HAVE 30 SECONDS?

YES. I THINK EACH OF YOU HAVE ONE MINUTE.

I WILL TRY TO BE VERY QUICK. IN RESPONSE TO ONE OF JUSTICE ANSTEAD'S QUESTIONS, THE THIRD DISTRICT COURT OF APPEAL HAS RULED, IN A FRAUD CASE, THAT THE IMPPOSITION OF 30 DAYS APPLIES TO FRAUD. IN THE VIALS CASE, THE JURY FOUND THAT THERE WAS FRAUD, BUT THE COURT WEIGHED WITH THE INSURANCE COMPANY, BECAUSE IT WAS FOUND WITHIN 30 DAYS. I WOULD CALL THE COURT'S ATTENTION TO THE VIALS CASE. NUMBER TWO, ABOUT INSURANCE COMPANIES, THERE IS NO WHERE, ANYWHERE IN THE RECORD IN THIS CASE, OTHER THAN THAT THE INSURANCE COMPANIES, GENERALLY ARE DOING THEIR UTMOST AND BEST TO TRY TO COMPLY WITH THE LAW. THIRDLY, WE HAVE A LOT OF TALK ABOUT WHAT IS REASONABLE PROOF. THE REASON WE ARE UP HERE IS BECAUSE A SUMMARY JUDGMENT WAS ENTERED AGAINST THE INSURANCE CARRIER, BECAUSE WE DIDN'T HAVE THE MEDICAL REPORT WITHIN 30 DAYS. WE NEVER HAD A CHANCE TO PROVE TO ANY FACT FINDER THAT THERE WAS OTHER REASONABLE PROOF AVAILABLE. ALL WE WANT FOR THIS COURT TO DO IS REVERSE THE SUMMARY JUDGMENT THAT WAS ENTERED AGAINST STATE FARM, TO ALLOW US TO GO FORWARD WITH THE CASE AND LET A FACT FINDER, EITHER THE INJURY OR THIS WAS IN COUNTY COURT, I THINK IT IS GOING TO BE A JUDGE, TO DECIDE WHETHER OR NOT THERE WAS REASONABLE PROOF

AT ANY PARTICULAR POINT IN TIME AND WHETHER THE BILLS COME UNDER THE STATUTE. THAT IS WHAT WE ARE UP HERE, ASKING THIS COURT TO DO, JUST ALLOW US TO GO INTO THE RECORD. THERE IS A VERY SKETCHY RECORD IN THIS CASE, BECAUSE IT WAS DETERMINED VERY QUICKLY, BY THE COURT, AND ON A MOTION FOR SUMMARY JUDGMENT, THAT, BECAUSE THE MEDICAL REPORT WASN'T RECEIVED WITHIN 30 DAYS, THAT STATE FARM OUGHT CLAY --

I THINK YOU -- OUT --

I THINK YOU BETTER GIVE MR. STARK A CHANCE.

THANK YOU. THANK YOU, YOUR HONORS. AGAIN, ONLY REASONABLE AND NECESSARY AND RELATED CHARGES ARE COVERED UNDER THE STATUTE. THAT IS WHAT IS INTENDED. IN FACT, LAST KEY SAID -- LASKE SAID WE NOTE OF INTEREST THAT THAT IS A WHAT IS COVERED, REASONABLE MEDICAL EXPENSES ARE COVERED.

IS THERE SOMETHING IN THE NATURE OF COVERAGE, THIS DIDN'T HAPPEN IN AN AUTO ACCIDENT, WHATEVER, SEPARATE AND APART OF WHETHER WE ARE GOING TO FIGHT WITH YOU ON WHETHER IT WAS 15 OR 20 DOLLARS. IS THERE ANY WAY THAT WE CAN APPROACH ON SEPARATING THIS?

I DON'T KNOW THAT YOU CAN SEPARATE THEM, BUT THE WAY THE THIRD DISTRICT READS AND THE WAY IT HAS BEEN INTERPRETED BY THAT COURT, YOU CAN'T HAVE ALL, BECAUSE THE SUGGESTION THAT ALMA ADORE SAYS YOU CAN PUT ANYTHING YOU -- AMADORE SAYS YOU CAN PUT ANYTHING YOU WANT IN A POLICY, THAT ISN'T REASONABLE PROOF. YOU CAN PUT ANYTHING YOU WANT IN THE REPORT. I THINK THE LEGISLATURE SAID REASONABLE PROOF IS IF YOU DIDN'T FIND IT. IF REASONABLE IS FRAUD, I THINK THAT WOULD BE SUFFICIENT. IF YOU LOOK IN AND YOU LOOK AT THE POLICE REPORT, AND THERE ARE NO INJURIES REPORTED AND NOBODY GOES TO THE HOSPITAL AND IT IS A MINOR FENDER BENDER AND YOU GET A $5,000 MRI BILL, THAT SHOULD BE REASONABLE PROOF.

MR. STARK, I THINK YOUR TIME IS UP, BUT JUSTICE QUINCE WAS TRYING TO ASK.

JUST AS POINT OF INFORMATION, YOU SAID YOU HAD PAID PART OF THE BILLS IN THIS CASE?

YES.

SO HOW MUCH ARE WE TALKING ABOUT HERE?

I THINK WE ARE LOOKING AT ABOUT $5,000, SO IF YOU ARE GOING TO BE SAYING WE ARE NOT PAYING THESE BILLS ON A REGULAR BASIS, SUBJECT TO $25,000 OR $30,000 IN ATTORNEYS FEES THAT, IS NOT A GOOD BUSINESS PRACTICE. I DON'T THINK THE INSURORS ARE GOING TO DO IT.

YOU HAVE ABSED. THANK YOU. -- YOU HAVE ANSWERED. THANK YOU.