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Dan Ray Warren v. State Farm Mutual Automobile Insurance Co.

CHIEF JUSTICE: GOOD MORNING EVERYONE. WE ARE READY TO GO ON THE FIRST CASE. JUSTICE CANTERO IS RECUSED FROM THIS CASE BUT HE WILL RETURN FOR THE REMAINDER OF THE DOCKET AFTER WE FINISH WITH THIS CASE, SO WITHOUT FURTHER ADO, LET'S PROCEED.

GOOD MORNING. MAY IT PLEASE THE COURT. I AM IN PRIVATE PRACTICE IN DAYTONA BEACH. MY NAME IS LARRY POLL SKI. THIS SUCCINCTLY INVOLVES A MOTOR VEHICLE ACCIDENT WHICH OCCURRED IN 1989 AND DAN WARREN, WHICH HAPPENS TO BE A CRIMINAL DEFENSE ATTORNEY IN DAYTONA BEACH, RETAINED MY SERVICES AND ULTIMATELY SAW A DOCTOR WHO SAW HIM ON THREE OCCASIONS, THE LAST OCCASION BEING JULY 6 OF 1999. THE DOCTOR'S OFFICE ULTIMATELY BILLED MR. WARN'S NO-FAULT CARRIER -- MR. WARREN'S NO FAULT CARRIER STATE FARM, ON OR ABOUT AUGUST 9 OF 1999.

WAS THERE ASSIGNMENT?

NO. NO. THAT IS WHY WE ARE UP HERE.

WE GIVE THE LEGISLATURE AN ENORMOUS AMOUNT OF ROOM INCOMING UP WITH SCHEMES LIKE THIS, WITH REFERENCE TO MEDICAL INSURANCE AND INSURANCE LIKE THIS. CAN YOU START OFF WITH WHAT IS YOUR ISSUE THAT YOU ARE GOING TO DRIVE POINT ON HERE THIS MORNING, AS FAR AS, GO AHEAD.

CHIEF JUSTICE, SIR, WHAT I WANT TO TRY TO DRIVE HOME IS WHY CAN AN AMBULANCE, WHY CAN AN EMERGENCY ROOM, WHY CAN A HOSPITAL TAKE A YEAR TO SUBMIT A BILL, TWO YEARS TO SUBMIT A BILL, THREE YEARS TO SUBMIT A BILL TO A NO FAULT CARRIER, WHEN A DRR DOCTOR, A -- WHEN A DOCTOR, FOR INSTANCE, A NEURO SURGEON, AN ORTHOPEDIC SURGEON OR SOMEONE WHO COMES TO THE HOSPITAL IN THE MIDDLE OF THE NIGHT AND OPERATES ON SOMEONE WHO IS DYING AND CAN'T GET CREDIT FOR THE SERVICES. THAT PUTS A BURDEN ON THE PERSON WHO HAS TO COME AND SAVE THE LIFE AND PUTS THE BURDEN ON THEM. THE ARGUMENT MADE BY STATE FARM WHERE THESE ARE ONE-TIME DEALS WHERE THE PERSON COMES TO THE EMERGENCY ROOM ONE TIME, THAT IS INACCURATE. A PERSON CAN GO TO THE EMERGENCY ROOM FOR A BONE SCAN, CT SCAN, MRI, TWO OR THREE TIMES GO TO THE HOSPITAL FOR THE CASE AND THAT HOSPITAL CAN SUBMIT A BILL FOR UP TO THE FIVE YEARS FROM THE FIRST DATE OF SERVICE.

IT ISN'T HOSPITALS COVERED UNDER THE STATUTE BUT ANY HOSPITAL SERVICES?

ANY HOSPITAL SERVICES. WHY WOULD ANYONE WANT TO GO TO MEDICAL SCHOOL ANYMORE, IF THAT PERSON HAS TO BECOME THE ASSURE OR FOR A -- THE INSUROR FOR AN ACCIDENT. YOU GO TO MEDICAL SCHOOL TO EARN A GOOD LIVING.

LET'S STAY ON THIS EQUAL PROTECTION ARGUMENT, THOUGH, AND I DO SEE THAT THERE ARE REASONS THAT THE LEGISLATURE COULD HAVE DISTINGUISHED HOSPITALS AND AMBULANCE SERVICES FROM DOCTORS, LOOKING, NOT YOUR DOCTOR BUT DOCTORS IN GENERAL, LOOKING AT THE REASONS THAT HAVE BEEN SET FORTH IN THE FIFTH DISTRICT OPINION, AND ISN'T IT TRUE THAT, IF WE FIND ANY REASON THAT SEEMS REASONABLE, THAT YOUR EQUAL PROTECTION CHALLENGE FAILS?

I AGREE, JUSTICE PARIENTE, THAT IF YOU FIND ANY REASON THAT ARGUMENT FAILS, BUT I DON'T BELIEVE YOU CAN FIND ANY REASON, AND I BELIEVE THAT IS BECAUSE THE ACT, ITSELF, IS CALLED THE NO FAULT ACT. THE IRONIC PART IS THERE IS NOTHING BUILT INTO 1.450, FOR INSTANCE, WHAT IF THE PERSON GIVES INCORRECT INFORMATION TO HIS DOCTOR? THE DOCTOR GETS INCORRECT INFORMATION AND SENDS IT OFF.

NOW YOU ARE GETTING OFF EQUAL PROTECTION, THOUGH, AND JUSTICE ANSTEAD WAS ASKING WHAT IS YOUR BEST ARGUMENT, BECAUSE IT DOES SEEM TO ME THAT IT IS GOOD TO REQUIRE SOME LIMITATION IN TERMS OF WHEN THE BILL GETS SUBMITTED, SO THE INSURANCE COMPANY CAN ASCERTAIN IF THE BILL IS RELATED OR DO WHAT THE INSURANCE COMPANY NEEDS TO DO, BUT YOU HAVE, HAVE YOU RAISED A SEPARATE CHALLENGE THAT, BECAUSE IT LACKS A FAIL-SAFE TYPE OF GOOD CAUSE EXCEPTION, THAT IT IS ARBITRARY AND CAP RISH US, AGAINST DOCTORS? I MEAN -- AND CAP RIRBS, AGAINST -- AND CAP RISH US, AGAINST DOCTORS? IS THAT THE ARGUMENT THAT YOU ARE MAKING?

I GAVE ALL OF THESE EXAMPLES, BOTH AT THE COUNTY COURT LEVEL, FIFTH DISTRICT LEVEL AND TO ALL OF YOURSELVES, AND I AM TELLING YOU, ALL, THAT AS FAR AS EQUAL PROTECTION, HOW CAN THERE BE EQUAL PROTECTION FOR A PRIVATE DOCTOR WHO CAN SEE A PERSON A YEAR AFTER AN ACCIDENT, ON A ONE-TIME ONLY BASIS, ONE TIME ONLY, SEES HIM IN EVALUATION OF, SAY, A NECK CONDITION, AND LET'S SAY HE GETS THE CORRECT INFORMATION AND HIS BILLING CLERKS DIE OF A HEART ATTACK ON THE 28th DAY. FOR NO FAULT OF HIS OWN, AGAIN WE USE THE WORD "FAULT", THIS IS NO FAULT OF HIS, HIS OFFICE CAN'T GET THE BILL OUT IN 30 DAYS. EQUAL PROTECTION RIGHT THERE. THE HOSPITAL, IF THEIR BILLING CLERK DIES, IT DOESN'T REALLY MATTER, BECAUSE THEY CAN SUBMIT THE BILL ANY TIME UP TO FIVE YEARS. IT IS A POOR CONTRACTOR'S OPTION, BUT IF THE DOCTOR'S CLERK DIES ON THE 28th DAY, HE DOESN'T GET PAID THROUGH NO FAULT OF HIS OWN, AND THE BEST ARGUMENT I CAN MAKE IS WHAT IF HE GETS INCORRECT INSURANCE INFORMATION? AGAIN, THROUGH NO FAULT OF HIS OWN.

LET'S GET TO THE HYPOTHETICALS IN THIS CASE. IN THIS CASE YOUR PHYSICIAN WAS PROVIDING SERVICES ON A ROUTINE BASIS. IS THAT CORRECT?

JUSTICE, I WOULD DISAGREE. MY CLIENT ONLY SAW THIS PATIENT THREE TIMES.

WAS IT AN EMERGENCY?

NO.

THE STATUTE PROVIDES FOR EMERGENCY SERVICES, AND IT REFERS TO THE DEFINITION OF EMERGENCY SERVICES, WHICH INCLUDES PHYSICIANS, DOESN'T IT, OUTSIDE THE HOSPITAL PHYSICIAN, THE HOSPITAL BILLING?

THAT'S CORRECT.

SO IF YOUR CLIENT, IF THE DOCTOR HAD SEEN THE CLIENT ON AN EMERGENCY BASIS, THEN THE STATUTE DOES PROVIDE FOR AN EXCEPTION. IS THAT CORRECT?

NO. NO. HE WOULD HAVE TO SEE HIM, NO, IT DOESN'T PROVIDE FOR ANYTHING OTHER THAN EMERGENCY ROOMS, HOSPITALS, AND AMBULANCES. IT DOESN'T PROVIDE FOR THE NEURO SURGEON OR ORTHOPEDIC SURGEON THAT IS ON CALL AND GOES TO THE EMERGENCY ROOM AND OPERATES.

I AM LOOKING AND IT SAYS EMERGENCY SERVICES AND CARE AS DEFINED IN 395.002, AND THAT SECTION SAYS EMERGENCY SERVICES AND CARE MEANS MEDICAL SCREENING AND EXAMINATION BY A PHYSICIAN OR TO THE EXTENT PERMITTED BY APPLICABLE, BY OTHER APPROPRIATE

PERSONNEL, UNDER THE SUPERVISION OF A PHYSICIAN, ET CETERA. IT DOESN'T LIMIT IT TO AN EMERGENCY ROOM.

I BELIEVE THAT THE INTERPRETATION THAT WOULD BE FOR EMERGENCY ROOM PURPOSES ONLY, JUSTICE BELL, WOULD NOT BE FOR THE DOCTOR, THE PRIVATE PHYSICIAN ON CALL. I DO NOT, I DO NOT AGREE WITH YOU JUSTICE BELL. I BELIEVE THAT ANY PRIVATE PHYSICIAN ON CALL, WHO COMES TO THE EMERGENCY ROOM, WOULD NOT BE DEFINED UNDER THAT STATUTE AS EMERGENCY ROOM SERVICES.

TWO QUESTIONS. THAT IS NOT BEFORE US, ONE, THAT IS NOT WHAT HAPPENED IN THIS CASE.

NO.

TWO, ARE THERE RULES INTERPRETING THIS STATUTE, WHICH LIMITS THIS STATUTE AS YOU SUGGEST?

IT IS MY UNDERSTANDING THAT THAT, IT IS MY UNDERSTANDING, FROM MY 28 YEARS IN PRACTICE, THAT THAT STATUTE ONLY RELATES TO EMERGENCY ROOMS, AND THAT WOULD BE THROUGH OTHER CASES I HAVE HANDLED IN THE MEDICAL MALPRACTICE AREA, ET CETERA. IT DOES NOT APPLY TO PRIVATE PHYSICIANS WHO HAVE TO COME TO AN EVENT R IN THE MIDDLE OF THE NIGHT, SAY A PLASTIC SURGEON WHO HAS TO STITCH UP SOMEONE'S ARM THAT IS DANGLING T THAT PERSON HAS TO SUBMIT HIS BILL WITHIN 30 DAYS BUT FORGET ABOUT THAT. GOING BACK TO MY ARGUMENT, THE BEST ARGUMENT I CAN GIVE YOU, THE PERSON COMES TO THE HOSPITAL TWO YEARS LATER, AFTER THE ACCIDENT, FOR A CT SCAN, FOR A MYELOGRAM, THAT HOSPITAL HAS THE LUXURY ANY TIME IT WANTS UP TO FIVE YEARS AND THAT IS JUST PLAIN WRONG. IT DOESN'T COMPORT WITH ANY RATIONAL BASIS. IT DOESN'T ALLOW EQUAL PROTECTION FOR A PRIVATE IMAGING SERVICE WHO WOULD PERFORM THE SAME MRI OR SAME MYELOGRAM OR SAME CT SCAN AND BONE SCAN. THEY, FOR SOME REASON, HAVE TO SUBMIT THEIR BILL WITHIN 30 DAYS AND REALLY I CAN ONLY GIVE YOU THE FACTS OF THIS CASE, BUT THE OWN THAT IT IS -- BUT THE REASON THAT IT IS, THE REASON THAT THE COUNTY COURT JUDGE DID STRIKE THIS DOWN IS BECAUSE OF ALL OF THESE MANY, MANY, MANY INSTANCES THAT OCCUR ON A DAILY BASIS, WHERE PEOPLE CAN'T GET THE BILLS IN WITHIN 30 DAYS.

LET'S LOOK AT YOUR CASE. IT SEEMS TO ME THAT YOUR CLIENT WAS SEEN BY THIS PHYSICIAN ONLY THREE TIMES, BUT OVER A COUPLE OF MONTH'S PERIOD, AND ONE OF THE REASONS FOR THE STATUTE, AS I UNDERSTAND IT, IS SO THE INSURANCE COMPANY CAN BE INFORMED EARLY ABOUT THIS, SO THEY CAN LOOK TO SEE IF, IN FACT, THE SERVICES BEING RENDERED, TRYING TO DETERMINE IF THOSE SERVICES WERE REASONABLE AND RELATED TO THE ACCIDENT. YOUR CLIENT'S ACCIDENT WAS IN MARCH, I BELIEVE. THE FIRST TIME HE WENT TO THIS PARTICULAR PHYSICIAN WAS IN MAY, AND THEN HE WENT IN JUNE AND JULY, I BELIEVE, AND SO DOESN'T THAT SORT OF SUPPORT THE WHOLE IDEA THAT WE NEED TO HAVE THESE BILLS SENT IN A TIMELY FASHION SO THE INSURANCE COMPANY CAN INVESTIGATE THESE THINGS, AND NOW WE HAVE THE BILLS SIX MONTH'S TIME PAST, SO THE INSURANCE COMPANY THEN SEES SOMEONE SEEKING TREATMENT FOR THE ACCIDENT.

THERE ARE MANY TIMES WHEN PEOPLE DON'T SEEK TREATMENT FOR MONTHS AND MONTHS AFTER THE ACCIDENT. IN THIS PARTICULAR CASE, THE DOCTOR WAS THREE DAYS LATE MAILING OUT HIS NOTICE. E-MAILED IT OUT AUGUST 9, 1999. IT DOESN'T MAKE ANY SENSE AT ALL. FIRST OF ALL, LET'S THROW THE FIRST VISITSITY OUT AND -- THROW THE FIRST VISIT OUT AND LET'S TALK ABOUT THE LAST VISIT. CAN YOU THINK OF ANY REASON WHY THAT BILL SHOULDN'T BE PAID IN THE INSURANCE COMPANY, WHEN THEY GET THE BILL, IF THEY DON'T THINK IT IS REASONABLE, NECESSARY, IF THEY THINK IT IS A BOGUS BILL THEY DON'T HAVE TO PAY IT, AND AT THAT POINT THEY CAN DENY IT AND EVERYONE GOES TO COURT AND THEY CAN ARGUE THE BILL, SO THE INSURANCE COMPANY DOESN'T HAVE ITS RIGHTS TAKEN AWAY.

WHAT JUDGE PARIENTE IS TALKING ABOUT IS THAT THAT GOES ON IN REAL LIFE. THERE ARE SOME MEDICAL PROVIDERS WHO WILL SEE A PERSON WHO IS INVOLVED IN AN AUTOMOBILE ACCIDENT 100 TIMES, WITHIN 150 DAYS, AND THE INSURANCE COMPANY HAS TO HAVE, COULD REASONABLY HAVE SOME NOTICE, IN ORDER TO HAVE THAT PERSON EXAMINED, IN ORDER TO TEST MEDICAL NECESSITY OF THOSE 100 VISITS. ISN'T THAT A RATIONAL REASON TO HAVE THIS STATUTE THIS WAY?

I AGREE WITH YOU, JUSTICE WELLS. I ABSOLUTELY AGREE WITH YOU, AND IF THE STATUTE HAD READ THAT WAY, I WOULDN'T BE HERE, AND IF IT HAD SAID, LOOK, WE ARE SAYING THAT WE DON'T WANT BULK BILLING. WE DON'T WANT SOMEONE WHO HAS SEEN A DOCTOR MORE THAN TEN OR 20 OR 30 TIMES, NOW WE ARE TALKING ABOUT A RATIONAL OBJECTIVE, BUT IT DOESN'T SAY. THAT DOESN'T ALLOW FOR THAT. IT DOESN'T ALLOW FOR EXCUSEABLE NEGLECT. IT DOESN'T ALLOW FOR WRONG INFORMATION BEING GIVEN TO A DOCTOR. IT DOESN'T ALLOW FOR ANY OF THAT, AND IT SHOULD SPELL IT OUT, SO WHAT IT DOES --

DO YOU KNOW WHY IN THIS CASE, THE BILL WAS SENT IN THREE DAYS LATE? IS THERE ANYTHING IN THE RECORD AS TO --

NO. MY GUESS, THE BEST GUESS I HAVE --.

I DON'T WANT A GUESS. I JUST THOUGHT MAYBE THE RECORD HAD ESTABLISHED WHY THE DOCTOR'S OFFICE HAD, MAYBE THEY DID HAVE THE WRONG INSURANCE INFORMATION, BUT --

NO, BUT STATE FARM, I CAN TELL YOU THIS, STATE FARM DIDN'T CARE. THEY DENIED IT ARBITRARILY AND DISEASE I FEEL AND SAID THIS IS THREE DAYS -- AND DESIZEIVELY AND SAID THIS IS THREE DAYS LATE. WE CAN'T PAY IT. HOW CAN THAT BE A RATIONAL BASIS FOR AT LEAST --

THEY HAVE THE RIGHT TO DEN UNDER THE STATUTE.

THE DRACK -- TO DENY UNDER THE STATUTE.

THE DRACONIAN STATUTE, WHERE A PERSON SENDS IN HIS BILL ONE TIME THREE DAYS LATE AND DOESN'T GET PAID.

IS MR. ROCK STEEN, NOW, PRECLUDED FROM SUING YOUR CLIENT, MR. WARREN?

YES.

I AM GOING TO ASK STATE FARM ABOUT THIS. YOU DIDN'T RAISE AN ISSUE OF WHETHER THIS INTERFERES WITH THE RIGHT OF CONTRACT, BUT YOU SAID THERE IS NO ASSIGNMENT THAT HAS BEEN TAKEN.

THAT'S CORRECT.

SO IF DR. ROTH STEEN DIDN'T WANT TO SUBMIT THE BILL, IS IT ONLY WHEN YOU SUBMIT THE BILL AND IT IS UNTIMELY, THAT THE INSURED IS RELIEVED OF THE OBLIGATION TO PAY? HOW DOES THAT WORK?

THAT IS HOW THE STATUTE READS.

SO IF THE DOCTOR SAID I AM NOT GOING TO SUBMIT THIS BILL FOR YOU, THEN IT WOULD BE THE INSURED'S OBLIGATION TO SUBMIT IT WITHIN 30 DAYS?

CORRECT. AND IN THIS PARTICULAR CASE, YOU ARE ABSOLUTELY CORRECT, JUSTICE PARIENTE,

THAT DAN WARREN, WHO, LIKE I SAY, WHO IS AN ATTORNEY, COULD NOT BE SUED, PURSUANT TO THE STATUTE, WHICH IS AN ABSURD RESULT.

THAT IS ONLY BECAUSE THE DOCTOR CHOSE TO SAY THAT HE WOULD SUBMIT THE BILL FOR MR. WARREN.

THAT'S CORRECT. AND, AGAIN, WHAT IF THE DOCTOR GOT THE WRONG INSURANCE INFORMATION? WHAT IF THE DOCTOR'S BILLING DEPARTMENT FELL APART ON THE 30th DAY?

CAN'T DOCTORS PROTECT THEMSELVES BY TELLING THEIR PATIENTS THAT THEY WILL NOT SUBMIT THE BILL AND REQUIRING THE INSURED TO SUBMIT THE BILL?

YES, THEY CAN, BUT THEN YOU RUN INTO MANY, MANY CLIENTS WHO, I AM SURE ALL OF YOU AND MYSELF HAVE REPRESENTED OVER THE YEARS, ARE IN CAPABLE OF SUBMITTING THE BILL ON TIME. THEY ARE ILLITERATE. THEY ARE UNWILLING TO SUBMIT THE BILL ON TIME.

WE DON'T HAVE, THE FACTS OF THE CASE BEFORE US, WE CAN WHAT-IF FOREVER, BUT THE FACTS OF THE CASE BEFORE US, YOU HAVE NO REASON FOR THE DOCTOR FAILING TO SUBMIT THE BILL, OTHER THAN FAILING TO FILE THE BILL ON TIME, JUST LIKE IF WE FAIL TO FILE A BILL ON A TIMELY BASIS, THERE IS NO EXCUSE OF GOOD CAUSE OR ANY OF THOSE THINGS, BUT IN THIS CASE THERE IS NO GOOD CAUSE FOR FAILING TO SUBMIT THE BILL WITHIN THE 30-DAYTIME FRAME.

THAT'S CORRECT, AND I HAVE TO USE THIS WORD "MIGHT", BECAUSE I AM ATTACKING THE WHOLE ACT, AND WHEN I ATTACK THE WHOLE ACT, I HAVE TO THROW OUT EVERY CONCEIVABLE EXAMPLE I CAN THINK OF, THAT MIGHT CONVINCE YOU FOLKS TO SUSTAIN THE COUNTY COURT. SAY A DOCTOR IS GIVING LIFE-SAVING SERVICES TO A PATIENT, CAN'T HAVE ANY EXCUSE NEGLECT OR ANY LITIGANT CAN COME IN ON THE 31th DAY AND SAY I AM DEFAULTED. THE REASON I FILED IT ON THE 31 DAY IS BECAUSE I GAVE THE WRONG ADDRESS.

CHIEF JUSTICE: THE MARSHAL HAS REMINDED US THAT YOU ARE INTO YOUR REBUTTAL TIME. IF YOU WANT TO PAUSE NOW.

GOOD MORNING. I AM KAREN BARNETT FROM BARNETT AND ASSOCIATES FROM TAMPA. I REPRESENT THE RESPONDENT AND WITH ME IS MY ASSOCIATE DEBORAH APPEL. WE BELIEVE THAT THE FIFTH DISTRICT WAS CORRECT IN ITS HOLDINGS. MUCH OF THE ARGUMENT I WOULD MAKE WOULD, OF COURSE, BE FROM THAT OPINION, AND WE FEEL THAT PETITIONER HAS FAILED TO MEET THEIR HEAVY BURDEN WITH RESPECT TO THEIR CONSTITUTIONAL CHALLENGE OF THIS PROVISION OF THE STATUTE.

WHY ISN'T IT REASONABLE TO CREATE A SEPARATE CATEGORY FOR TREATING PHYSICIANS AND THEN EXEMPT HOSPITALS AND EMERGENCY MEDICAL PROVIDERS AND THESE OTHER CATEGORIES? WHERE IS THE LOGICAL LINE DRAWN, IN THERE, TO BE, HAVE THIS VERY, VERY STRICT RULE FOR THE PHYSICIANS THAT ARE PROVIDING THESE MEDICAL SERVICES IN GOOD FAITH TO THEIR PATIENTS? AND YET MAKE A SEPARATE CATEGORY FOR HOSPITALS.

YES. I BELIEVE THAT THERE IS A REASONABLE BASIS FOR THAT DISTINCTION, WHICH IS ALL THAT WE HAVE TO SHOW TO PASS THE CONSTITUTIONAL MUSTER, BUT THAT IS BECAUSE, IN AN EMERGENCY SETTING, OBVIOUSLY IF SOMEBODY IS COMING IN BY AMBULANCE AND THEY ARE COMING NORMALLY FROM THE SCENE OF AN ACCIDENT TO THE HOSPITAL, IT IS A RELATIVELY STRAIGHTFORWARD MATTER.

YOUR OPPONENT HAS POINTED OUT THAT THERE ARE MANY SERVICES RENDERED AT HOSPITALS THAT AREN'T RENDERED ON AN EMERGENCY BASIS, THAT WOULD APPEAR TO BE COVERED HERE. THAT IS THESE DIAGNOSTIC TESTS AND THINGS THAT ARE GENERALLY ONLY PROVIDED IN A

HOSPITAL SETTING, YOU KNOW, BECAUSE OF THE SIZE OF THE EQUIPMENT OR THE NATURE OF THE DIAGNOSTIC PROCEDURE, SO --

IT IS CORRECT THERE ARE GOING TO BE A FEW OCCASION IT ISS, AS YOUR HONOR -- OCCASIONS, AS YOUR HONOR SUGGESTED, THAT THE HOSPITAL WOULD PERHAPS RECEIVE A BENEFIT IN THAT RESPECT, BUT THAT IN AND OF ITSELF DOES NOT MAKE THE MATTER UNCONSTITUTIONAL. AS LONG AS THERE IS A BASIS FOR THE DISTINCTION, WHICH THERE IS, IN AN EMERGENCY VERSUS A NONEMERGENCY SITUATION, CERTAINLY, I DON'T THINK THAT MAKES IT IN AND OF ITSELF NONCONSTITUTIONAL. I DON'T THINK THAT IS A DISTINCTION BETWEEN A HOSPITAL AND AN OUTSIDE PRIVATE PROVIDER THAT IS GOING TO TURN THIS THING AROUND.

BEYOND THE EMERGENCY SIGNED, WHAT OTHER VALID DISTINCTION IS THERE, IF WE ARE NOW APPLYING IT TO OTHER SITUATIONS THAT ARE NONEMERGENCY, BUT YET THERE IS A SEPARATE CATEGORY.

THE DISTINCTION BETWEEN THE HOSPITAL AND THE PRIVATE PHYSICIAN?

RIGHT.

I MEAN, I DON'T KNOW THAT THAT THERE IS ANY DISTINCTION OTHER THAN THE PUBLIC WELFARE AND THE HOSPITALS ARE ALREADY STRESSED ENOUGH WITH THE PATIENTS THAT THEY HAVE TO SEE AND I GUESS NOT TO PUT THE BURDENS ON THE HOSPITALS.

THIS PHYSICIAN DID AN EXAMINATION AT HIS OFFICE, PRESUMABLY THIS 30-DAY RULE WOULD BAR A CLAIM FOR THAT.

THAT'S CORRECT.

WHEREAS IF THE DOCTOR SENDS THE PATIENT TO THE HOSPITAL FOR THAT SERIES OF X RAY EXAMINATIONS, THEN THERE ARE NO LIMITATIONS. AM I CORRECT?

I THINK THERE IS A LIMITATION, CONTRARY TO WHAT COUNSEL INDICATES. MOST OF THE INSURANCE POLICIES AND ALL OF THE OTHER PROVISIONS OF THE PIP STATUTE, DO TALK ABOUT REASONABLE PERIODS OF TIME.

BUT THE 30-DAY RULE WOULD NOT APPLY.

I DO NOT BE BELIEVE -- I DO NOT BELIEVE IT WOULD APPLY. STRICTLY TO THE HOSPITAL.

HOW DOES THAT FIT WITH I AM IN MY OFFICE AND I AM COVERED BY THIS AND I SEND YOU TO THE HOSPITAL AND NOW THE 30-DAY THING DOESN'T EVEN APPLY, SO YOU CAN BILL FOR THAT ANY TIME. DOESN'T THAT SEEM TO BE ARBITRARY, THAT REALLY IT IS THE SAME DOCTOR THAT IS PRESCRIBING, ASKING FOR THE NEED FOR THESE DIAGNOSTIC TESTS? IT IS JUST A MATTER OF, YOU KNOW, ONE HAVING THE CAPABILITY, AND DOESN'T THAT APPEAR TO BE COMPLETELY ARBITRARY, AT LEAST IN THE THAT FACTUAL SETING THAT I DESCRIBED?

I DON'T THINK IT IS COMPLETELY ARBITRARY. THE LEGISLATURE DOESN'T HAVE TO BE COMPLETELY PERFECT. THE LESKY CASE DOESN'T FORBID THE LEGISLATURE FROM DETERMINING ON A LIMITED BASIS, HOW WELL OR HOW BADLY A PROPOSED COURSE OF ACTION WORKED, WHEN PUT INTO PRACTICE. JUST BECAUSE THAT ONE SMALL AREA MAY NOT BE PERFECT DOESN'T RENDER IT UNCONSTITUTIONAL. I THINK WHAT THEY WERE TRYING TO DO POSSIBLY, AND UNFORTUNATELY THIS IS ONE PART OF THE STATUTE WHERE THE HOUSE BILL AND THE OTHER FILINGS THAT WE HAVE MADE WITH THE LEGISLATIVE INTENT DOESN'T REALLY DISCUSS THAT PARTICULARLY, BUT I AM SURE IN ONE RESPECT IT IS SOMEWHAT TO PROTECT HOSPITALS, AND IN THE OTHER SENSE I THINK PROBABLY DID NOT COUNTERTHAT IT WOULD REALLY -- DID NOT

CONSIDER THAT IT WOULD REALLY BE A PROBLEM, BECAUSE NORMALLY IT IS DONE ON AN EMERGENCY BASIS, IF IT IS NOT A HOSPITAL.

YOU MAY HELP ME IN INTERPRETING THIS, BUT BROADLY, DOES THE STATUTE PROVIDE THE PROVISION THAT, IF HE DOESN'T DOM PLY WITH THE 30-DAY BILLING -- COMPLY WITH THE 30-DAY BILLING REQUIREMENT TO THE INSURANCE COMPANY, IS BARRED FROM HAVING ANY LEGAL CLAIM AGAINST THE PATIENT?

IT ABSOLUTELY DOES. IF THE PHYSICIAN --

HOW CAN YOU TAKE AWAY, LET'S SAY THAT THE PATIENT COMES TO THE DOCTOR, AND THE DOCTOR SAYS I HAVE HAD IT WITH INSURANCE COMPANIES, AND WE NO LONGER COVER BLUE CROSS/BLUE SHIELD OR WHATEVER THE THING IS THAT WE, YOU KNOW, WE TRIED, AND YOU KNOW, IT HAS COST US HUNDREDS OF THOUSANDS OF DOLLARS TO SET UP AN ADMINISTRATIVE, AND SO IF YOU ARE GOING TO ASSIGN -- AND SO YOU ARE GOING TO SIGN A WAIVER HERE THAT WE DON'T BILL THE INSURANCE COMPANY. YOU BILL. YOU CAN COLLECT FROM THE INSURANCE COMPANY, BUT YOUR OBLIGATION IS DIRECTLY TO US. WE HAVE NOTHING TO DO WITH INSURANCE. WHATEVER. TO THE MOST EXTENT POSSIBLE. ARE YOU SAYING THAT, UNDER THIS STATUTE, THAT AGREEMENT BETWEEN THE PATIENT AND THE DOCTOR WOULD BE TOTALLY INVALID?

I AM NOT SURE I UNDERSTAND WHAT YOU ARE ASKING ME, BUT IF THE DOCTOR DECIDED HE WASN'T ACCEPTING NO-FAULT BENEFITS OR ANY OTHER TYPE OF BENEFIT AND THE INSURED WAS TO SUBMIT THE BILL DIRECTLY TO THE COMPANY, I BELIEVE A STRICT READING OF THE STATUTE WOULD NOT REQUIRE NECESSARILY THAT THE COMPANY REIMBURSE THE INSURED WITHIN THOSE 30 DAYS. IT IS THE PHYSICIAN WHO IS ELECTING, LET ME BACK UP AND SAY THERE IS NO PROOF ANYWHERE IN THIS RECORD THAT THIS PHYSICIAN DOES NOT HAVE ASSIGNMENT. THAT IS NOT IN THE RECORD ANYWHERE. WE DON'T KNOW WHETHER THE PHYSICIAN HAS ASSIGNMENT OR NOT. THE HEALTH INSURANCE CLAIM FORM THAT HE IS REQUIRED TO SUBMIT, UNDER PENALTY OF PERJURY, CHECKED, YES, THAT HE DID HAVE ASSIGNMENT, SO I DON'T BELIEVE THE RECORD IS REALLY CLEAR IN THAT EFFECT, BUT IF THEY ARE GOING TO ACCEPT ASSIGNMENT AND BILL THE INSURANCE COMPANY DIRECTLY AND PLACE THEMSELVES IN THAT POSITION, THEN THEY MUST COMPLY WITH THE STATUTE, AND IF THEY DON'T DO SO, WE ARE NOT TO PAY FOR THAT BENEFIT, ON BEHALF OF THE INSURED, AND DEPLETE THEIR BENEFITS, WHEN THE LAW SAYS WE CAN'T DO THAT.

SO JUST, I WANT TO MAKE SURE, IF IT IS ANY HOSPITAL, IT IS NOT JUST EMERGENCY ROOM, CORRECT? ANY HOSPITAL CHARGES ARE NOT SUBJECT TO THIS PROVISION.

THAT IS THE WAY THAT IT READS.

HOW ABOUT, ARE YOU SAYING THAT THE INJURED PERSON, IF THE DOCTOR CHOOSES NOT TO SUBMIT THE BILL, ARE YOU SAYING THAT THIS INJURED PERSON DOES OR DOES NOT HAVE THE 30-DAY LIMIT TO SUBMIT PAYMENT TO THE INSURANCE COMPANY?

THE WAY IT READS WITH RESPECT TO ANY TREATMENT OR SERVICE OTHER THAN MEDICAL SERVICES BILLED BY A HOSPITAL OR SERVICES PREPAREDERRED AT A HOSPITAL, THE STATEMENT OF CHARGES MUST BE FURNISHED TO THE INSUROR BY THE PROVIDER.

BUT THIS ONLY APPLIES TO AUTOMOBILE PIP CASES. THE STATUTE WE ARE TALKING ABOUT DOESN'T APPLY TO EVERY PHYSICIAN FOR EVERY PATIENT, FOR EVERY NEED.

IT DOES NOT.

IT IS LIMITED. HELP ME OUT. WHERE ARE WE LIMITED, AS TO THIS STATUTE?

WE ARE LIMITED TO, YOU KNOW, IF THEY ONLY HAVE PIP ONLY WITH NO MEDICAL PAYMENTS COVERAGE, THE 80 PERCENT THAT WOULD BE COVERED BY NO FAULT, AND IF IT ISN'T SUBMITTED --

THAT IS ALL WE ARE TALKING ABOUT IS PIP COVERAGE, NOT APPLYING FOR EVERY PHYSICIAN IN EVERY CIRCUMSTANCE.

THAT IS THE BILLING OF THE HEALTH INSURANCE COMPANY, WHICH IS EVERY REASON TO GET IT IN TIMELY. EVERY HEALTH INSURANCE COMPANY NORMALLY HAS THE REQUIREMENT THAT YOU HAVE TO SUBMIT THE BILL TO THEM WITHIN 30 DAYS OR THEY WON'T PAY.

IF YOU WILL ANSWER JUSTICE ANSTEAD'S QUESTION AND JUSTICE PARIENTE'S QUESTION, YOU HAVE REVERSED IT EVERY TIME THEY HAVE ASKED, AND THAT IS IF THE DOCTOR DOES NOT SUBMIT THE BILL TO THE INSURANCE COMPANY, WHAT HAPPENS IN THAT SCENARIO, AND YOU HAVE REVERSED IT EVERY TIME AND ASSUMING THAT THE DOCTOR SUBMITS THE BILL TO AN INSURANCE COMPANY. WHERE A DOCTOR DOES NOT SEND IT TO AN INSURANCE COMPANY AND FOR WHATEVER REASON, DOESN'T GET A BILL, EVEN, TO THE INSURED WITHIN 30 DAYS, WHAT HAPPENS?

HE IS NOT GOING TO BE PAID BY NO-FAULT.

AND HE HAS NO RECOVERY AGAINST THE PERSON HE HAS TREATED, EITHER.

THAT'S CORRECT.

AND HE HAS NO CAUSE OF ACTION IN COUNTY COURT?

NOT AGAINST THE NO-FAULT CARRIER OR AGAINST THE INSURED.

SO, DON'T YOU THINK, DOESN'T THAT SEEM PRETTY HARSH. A DOCTOR, IN GOOD FAITH, RENDERS SERVICE TO A PATIENT, AND YET IF HE DECIDES TO ACCEPT BILLING ON BEHALF THAT PATIENT, HE IS STUCK WITH THE BILL, IF HE SENDS IT IN ON THE 31th DAY.

NO. THIS, THESE ARE ALL NONEMERGENCY SITUATIONS. THERE IS NO REASON, AND IN PRACTICAL APPLICATION WHAT WE SEE IS THESE PEOPLE HAVE TO CALL AHEAD TO MAKE AN OINTMENT -- AN APPOINTMENT. THE DOCTOR'S OFFICE CALLS TO VERIFY THAT THE PERSON IS INSURED, THAT THEY HAVE THE BENEFITS AVAILABLE, OR THAT PERSON LIKELY WILL NOT BE ABLE TO GET THE APPOINTMENT AND EVEN BE ABLE TO WALK IN THE DOOR FOR THE TREATMENT. THEY HAVE ALL THAT TIME, BECAUSE THIS IS A NONEMERGENCY SITUATION, TO --

THIS IS A NONEMERGENCY SITUATION, I AM ASSUMING. I COULD BE IN AN ACCIDENT AND TOMORROW CALL THE DOCTOR AND SAY, LOOK, I WAS IN AN ACCIDENT. ISN'T URGENT, BUT THE DOCTOR DECIDES TO SEE ME TODAY, AND I, YOU KNOW, GET THERE AND GIVE THEM THE INSURANCE INFORMATION, ET CETERA. WHAT YOU ARE SAYING, THEN, IS WE SHOULD AGREE THAT THE DOCTOR IS STUCK WITH THE BILL, IF ON THE 31th DAY, THE BILL GOES OUT AND NOT THE 30th DAY.

IF IT IS NOT POSTMARKED WITHIN 30 DAYS. I BELIEVE THAT THE 30 DAYS IS A REASONABLE TIME FRAME WITHIN WHICH THEY WOULD HAVE TO SUBMIT THE BILL TO THE CARRIER. THE CARRIER ONLY HAS 30 DAYS TO VERIFY COVERAGE, THAT THIS PERSON IS AN INSURED, THAT THE CARE IS REASONABLE AND NECESSARY AND RELATED.

EXCUSE ME, MA'AM. DIDN'T WE JUST DECIDE A CASE THAT THAT IS NOT A TIME LIMIT? DIDN'T THIS COURT DECIDE THAT 30 DAYS WAS NOT A TIME LIMIT? LAST FALL. THE 30 DAYS MEANS NOTHING.

WAS IT NOT? THE 30 DAYS MEANS NOTHING FOR THE INSURANCE COMPANY TO PAY.

IF THEY DON'T PAY ON THE 30th DAY AND THEY HAVE NO REASON TO DEFEND THE CLAIM AND THEY GO INTO COURT AND THEY ARE SUED ON THE 31th DAY --

THEY CAN ALWAYS CHALLENGE THE REASONABLENESS, NECESSITY, WHETHER IT SHOULD HAVE BEEN, THEY CAN ALWAYS CHALLENGE IT. THERE IS NO, UNDER FLORIDA LAW, PROHIBITION AGAINST AN INSURANCE COMPANY CHALLENGING ANY BILL AT ANY POINT IN TIME NOW, IS THERE?

I BELIEVE THAT THERE IS, YOUR HONOR, YES.

WHERE?

I BELIEVE THAT THERE IS STILL GOOD FAITH REQUIREMENTS IN THE STATE THAT THE INSURANCE COMPANY HAVE A REASONABLE BASIS NOT TO PAY THE CLAIM WITHIN THAT TIME FRAME.

DID YOU READ THE LAST OPINION OF THIS COURT?

YES, YOUR HONOR.

WITH REGARD TO THE 30 DAYS MEANING NOTHING?

I DON'T KNOW THAT THAT IS THE CASE. I KNOW THAT YOUR DISSENT SEEMS TO THINK THAT THAT WAS A PROBLEM WITH WHAT HAPPENED WITH THE STATUTE, BUT I THINK THE PENALTIES ASSOCIATED WITH THE INSURANCE COMPANY NOT PAYING --

IS INTEREST. 10 PERCENT INTEREST.

AND LARGE AMOUNTS OF ATTORNEYS FEES HAD, IN MOST --

THAT HAS ALWAYS BEEN THERE, HAS IT NOT, UNDER 428?

YES, SIR.

I AM STILL JUST WANTING TO MAKE SURE I UNDERSTAND WHO IS GETTING THE SHORT END OF THE STICK IN THIS STATUTE. IF THE DOCTOR, IF I MAKE AN APPOINTMENT WITH THE DOCTOR, AND THE DOCTOR, I SEE THE DOCTOR MULTIPLE TIMES, WITHIN A 60-DAY PERIOD, AND MY DOCTOR SAYS I AM NOT GOING TO SUBMIT THIS BILL FOR YOU BECAUSE OF THIS STATUTE, AND MORE THAN 30 DAYS AFTER TREATMENT, I AM NOT GOING TO SUBMIT THIS BILL TO MY CARRIER, CAN THEY SAY THAT I DIDN'T SUBMIT THE BILL TIMELY, OR IS IT ONLY, IF IT IS THE MEDICAL PROVIDER WHO DECIDES, AGREES WITH THE PATIENT THAT, BECAUSE THEY HAVE GOT THE ABILITY TO DO THE BILLING AND THEY HAVE GOT A BILLING CLERK, THAT THEY WILL SUBMIT IT. THAT THEY WILL SUBMIT IT. AM I OR AM I NOT SUBJECT TO THIS STATUTE?

I BELIEVE THAT THE STRICT INTERPRETATION WOULD BE THAT YOU, AS THE INSURED, ARE NOT. IT IS ONLY DISCUSSING WHEN THE PROVIDER SUBMITS THE PAYMENT, AND THAT IS FOR THE LEGITIMATE LEGISLATIVE PURPOSE OF AVOIDING BULK BILLING. THE PROBLEM IS A LOT OF THESE PHYSICIANS ARE --

WHAT IF MY DOCTOR DOESN'T BILL ME EVERY TIME AND JUST BILLS ME AFTER SEVERAL MONTHS. ISN'T THAT THE SAME PROBLEM THAT THE INSURANCE COMPANY IS FACED WITH? I MEAN, IT SEEMS THAT SOMEWHAT, WHY ARE WE PICKING OUT DOCTORS WHO ARE, IN GOOD FAITH, RENDERING TREATMENT TO THEIR PATIENTS, AS THE ONES THAT ARE GOING TO SUFFER, BY THIS ARBITRARY TIME LIMIT.

THE LEGISLATIVE INTENT, YOUR HONOR, WAS TO AVOID BULK BILLING. IT WAS NOT THE PURPOSE. THE TIME LIMIT IS SO THAT ONLY THE 30 DAYS' WORTH OF BILLS WILL BE EVALUATED.

CAN'T DOCTORS GET AROUND IT BY SAYING I AM NOT GOING TO DO THE BILL. I WILL DO ALL THE PAPERWORK FOR YOU BUT YOU, INSURED ARE GOING TO SUBMIT IT, AND YOU SUBMIT IT WHENEVER YOU WANT?

THE POLICY --

THE DOCTORS ARE NOW GOING TO SAY THAT IT IS THE PATIENT THAT IS GOING TO SUFFER. THE PATIENT SAYS I AM NOT GOING TO SUBMIT THIS, BECAUSE I CAN'T AFFORD, IF IT IS SENT IN ON THE 31th DAY, I WON'T GET PAID, SO I WILL DO ALL THE PAPERWORK, BUT YOU SUBMIT IT, AND YOU CAN SUBMIT IT. YOU AREN'T SUBJECT TO THIS 30-DAY LIMITATION. ISN'T THAT A PROBLEM?

I DON'T KNOW HOW TO ANSWER THAT, BECAUSE WE DON'T HAVE A CASE TO THIS POINT OF TIME THAT, ADDRESSES ALL OF THOSE FACTS, BUT AT THIS TIME THE DOCTOR HAS TO FILL OUT A VERIFIED CLAIM FORM WHICH REFERENCES THE SERVICES RENT OFFERED AND THAT -- RENDERED AND ALL OF THAT SORT OF THING, SO WHEN THE TREATMENT IS DOCUMENTED, IT HAS TO BE PROVIDED TO THE INSURANCE COMPANY UPON THEIR REQUEST.

IS THERE ANY EVIDENCE THAT THAT IS HAPPENING, YOUR CONCERN, THAT WE ARE AWARE OF?

NO, NOT THAT WE ARE AWARE OF.

IS THERE A PROBLEM WITH WHAT THE LEGISLATURE LOOKED AT, AS FAR AS BULK BILLING BY HOSPITALS? I HAVE SEEN HERE ABOUT THE CONCERN BULK BILLING BY PHYSICIANS. WAS THERE A SIMILAR PROBLEM EVIDENCED IN THE LEGISLATIVE HISTORY OF HOSPITALS?

NO.

ARE YOU DEALING WITH BULK BILLING HERE? THREE? IS THAT CONSIDERED BULK BILLING, THREE VISITS?

THAT PARTICULAR INSTANCE IS NOT, I DON'T THINK WAS WHAT THE LEGISLATIVE CONCERN WAS.

SO THIS IS NOT, IN THIS CASE, BULK BILLING THIS. IS THREE VISITS, AND IN THIS CASE WE HAVE GOT A PHYSICIAN WHO HAS NOW BEEN CAUGHT BY THE NET OF AN INTENDED DESIGN TO CAPTURE BULK BILLING, THEN. THAT IS THE EVIL TO BE CORRECTED.

THAT IS THE EVIL, THAT THE COMPANY WOULD LIKE TO HAVE THE BILLS COME IN WITHIN A REASONABLE PERIOD OF TIME, WHICH I THINK THE LEGISLATURE HAS DETERMINED IS 30 DAYS, SO THEY CAN, THEN, DETERMINE RIGHT AWAY WHETHER IT IS REASONABLE AND NECESSARY BY HAVING AN IME AND HAVING AN EXAMINATION UNDER OATH, OF THE INSURED, IF THERE IS MAYBE A QUESTION, MAYBE THE PERSON HAD SEVERAL CAR ACCIDENTS AND THEY ARE TRYING TO DETERMINE WHICH PIP CLAIM TO PAY IT UNDER.

ARE THEY REQUIRED TO DO THOSE EXAMS WITHIN 30 DAYS?

AS YOU SAY UNDER THE CASE LAW, INNINGS. THE CASE LAW IS VERY STRONG THAT IF THE SUIT IS FILED WITHIN 30 DAYS, YOU ARE NO LONGER ENTITLED TO HAVE YOUR EXAMINATION WITHIN --

IF THE CASE HAS NOT BEEN FILED, YOU ARE ENTITLED TO HAVE IT AT ANY TIME, CORRECT?

YES. BUT THE PROBLEM WE ARE SEEING THE DOCTOR SUBMIT A BILL A YEAR AND-A-HALF OR

TWO YEARS LATER, FOR $5,000' WORTH OF BILL AND YOU GO TO A JURY AND SAY, YEAH, I HAD MY IME TWO YEARS LATER.

YOU ARE SAYING THAT SOMEBODY, DOCTORS WERE WAITING YEARS TO SUBMIT BILLS?

YES, YOUR HONOR.

SO HOW DID THEY, YOU ARE SAYING BUT INSURANCE COMPANY POLICIES HAD A REASONABLE REQUIREMENT IN THERE, REGARDLESS OF THE STATUTE.

WHAT THE POLICY SAYS, AND THERE IS ALSO A PROVISION OF THE STATUTE THAT SAYS THAT AN INSURANCE COMPANY MUST BE MADE AWARE OF THE CLAIM, AS SOON AS IS REASONABLE, BUT THAT IS SUBJECT TO --

DID SOMEBODY, WAS THERE A CONSIDERATION GIVEN, I GUESS IN A STATUTE FROM ANOTHER STATE HAS THIS, TO WHERE YOU HAVE GOT AT LEAST, IT IS A GOOD IDEA TO HAVE THESE TIMELY SUBMITTED. IT SEEMS TO ME IT WOULD BE GOOD FOR THE INSURED TO TIMELY SUBMIT IT, AND YOU KNOW, AS HOSPITALS TIMELY SUBMIT IT, BUT THERE BE AN EXCUSEABLE NEGLECT PROVISION, SO THAT YOU DON'T HAVE THIS DRACONIAN EFFECT, AND WE DON'T KNOW WHY HERE THERE IS A 3-DAY DELAY THAT CAN'T POSSIBLY, FOR THREE BILLS THAT CAN'T POSSIBLY PREJUDICE THE INSURANCE COMPANY. WAS THAT CONSIDERED IN THE DRAFTING OF THIS BILL, TO PUT AN EXCUSEABLE NEGLECT REQUIREMENT OR GOOD CAUSE FOR THE DELAY?

IT WAS NOT IN THIS PARTICULAR BILL. I KNOW IN SUBSEQUENT BILLS THAT, THERE IS A PROVISION, NOW, IF THE DOCTOR CAN PROVE THAT HE WAS PROVIDED WITH THE INCORRECT INFORMATION, THAT THAT WOULD BE THE CASE. OF COURSE WE DON'T HAVE THAT HERE. I MEAN, AS THE FIFTH DISTRICT NOTES, A SIMPLE, YOU KNOW, INPUT OF A VERY SIMPLE BILLING SYSTEM WOULD CERTAINLY HAVE GOT OVER THE PROBLEM.

SO WE DON'T HAVE THIS STATUTE ANYMORE. WE DON'T HAVE THIS PARTICULAR STATUTE IN EFFECT NOW?

WE DO. WE JUST NOW HAVE, AS YOU SAID, THEY HAVE ADDED A FAIL-SAFE PROVISION NOW, WHICH SAYS THAT THE DOCTOR CAN PROVE HE WAS PROVIDED WITH THE INCORRECT INFORMATION AND DID BILL THE WRONG INSURANCE COMPANY, BASED UPON WHAT THE INSURED WAS TELLING HIM, HE HAS THAT FAIL-SAFE DEVICE, AND THIS DOCTOR LIKELY WOULD HAVE HAD THAT, HAD HE BEEN ABLE TO SHOW THAT, BUT THE FIFTH DISTRICT, AS I SAY, THE REQUIREMENT THAT A STATEMENT BE RENDERED IN A TIMELY MANNER IS SATISFIED BY A SIMPLE MANAGEMENT SYSTEM AND PAVES THE WAY FOR PAYMENT TO THE PROVIDER. THIS IS A 1999 SITUATION, BUT IN PRACTICE, POINT EFFECT NOW, ALL OF THE BILLS ARE BEING SUBMITTED WITHIN 30 DAYS, SO THERE AREN'T ANY CASES COMING UP BEHIND THIS ONE. THERE IS NOT A LOT OF OTHER PROVIDERS WAITING IN THE WINGS WITH THESE TYPES OF SUITS BECAUSE THEY WEREN'T ABLE TO COMPLY WITHIN 30 DAYS. IT IS A VERY REASONABLE TIME FRAME, AND THEY WEREN'T ABLE TO SHOW THIS COURT WHY THE PRACTICAL MATTERS CAN'T COMPLY.

WHAT IF THEY PERFORM CERTAIN TESTING AND GO FOR PROCEDURES AND THEY SAY WE WILL PERFORM THE TESTING AND YOU COME BACK WITHIN TEN DAYS. ARE THEY CALCULATING IT FROM THE FIRST TREATMENT OR ARE THEY CALCULATING IT FROM THE FINAL? HOW IS THAT WORKING FROM A PRACTICAL MATTER? I CAN SEE SOME PROBLEMS THAT YOU CAN REDUCE THAT TIME DOWN TO TWO OR THREE DAYS, IF YOU SAY HERE IS THE PROVIDER PERIOD.

THE PROVIDER SENDS OUT A LETTER AND SAYS WE ARE GOING TO BE TREATING YOUR INSURED. WE WANT YOU TO KNOW THAT. THEY GET 60 DAYS NOW, INSTEAD OF 30.

IF THEY GIVE NOTICE.

YES. 60 DAYS FROM THE DATE THE SERVICES WERE RENDERED.

SO THEY MAY HAVE EARLY TESTING EARLY ON, BUT IT IS NOT THE PARTICULAR TREATMENT.

EACH DAY.

EACH DAY THAT YOU SEE THE INDIVIDUAL.

CHIEF JUSTICE: WE ARE GOING TO HAVE TO END ON THAT NOTE BECAUSE THE LIGHT HAS ON GONE ON. THANK YOU VERY MUCH. COUNSEL. HOW MUCH TIME DOES COUNSEL HAVE? OKAY. FINE.

MORE THAN AMPLE TIME.

IS THIS NOT EFFECTIVELY A NON-CLAIM PERIOD? SORT OF SIMILAR TO THE FACT OF, IN AN ESTATE SITUATION THERE IS A PERIOD OF TIME IN WHICH YOU HAVE TO SUBMIT A CLAIM, IF YOU DON'T, THE CLAIM IS BARRED?

I WOULD SAY THAT IT IS, JUDGE.

SO REALLY, THE, DOESN'T THE ISSUE HERE BOIL DOWN TO WHETHER 60, 30 DAYS IS A REASONABLE PERIOD OF TIME?

BUT JUSTICE WELLS, IN THE STATE SITUATION, THAT APPLIES TO ALL CREDITORS. CERTAIN CREDITORS, SUCH AS A HOSPITAL -- IN AN ESTATE SITUATION, THAT APPLIES TO ALL CREDITORS, SUCH AS A HOSPITAL IN A DECEDENT BEING TREATED, THEY HAVE --

I UNDERSTAND THE QUESTION BEING MADE. THE QUESTION IS WHETHER IT IS FOR THE LEGISLATURE TO MAKE A DETERMINATION.

ONLY IF YOU CONSIDER IT RATIONAL. JUSTICE QUINCE GAVE A GREAT EXAMPLE. WHAT IF I AM IN AN AUTOMOBILE ACCIDENT TODAY. I ELECT TO SEE MY FAMILY PHYSICIAN RATHER THAN GO TO AN ER ROOM.

BUT, AGAIN, ACCEPTING THAT, WHERE YOU HAVE THE TERMINATIONS THAT ARE MADE BY THE LEGISLATURE, ON THE BASIS THAT THEY ARE TRYING TO DIRECT THEIR ATTENTION TO WHAT THEY PER SIF -- PERCEIVE, RIGHT OR WRONG, IS A PROBLEM IN THE NO-FAULT SYSTEM. THEN DON'T, THE RATIONAL BASIS, IF THERE IS A REASONABLE BASIS, I MEAN, WE HAVE TO GIVE THE LEGISLATURE LATITUDE, DO WE NOT?

THEY DIDN'T SPELL IT OUT, SAYING WE ARE CREATING THIS FOR BULK BILLING. THEY DIDN'T SPELL IT OUT HERE. A PERSON CAN SUBMIT A BILL FOR LOST WAGES FIVE YEARS AFTER THE ACCIDENT BUT THE DOCTOR MUST PROVIDE A BILL WITHIN 30 DAYS, OR OTHERWISE THE DOCTOR HAS TO EAT THE BILL OR THEN IT SHIFTS TO THE MAJOR MEDICAL CARRIER. STATE FARM ELECTED TO WRITE NO-FAULT POLICIES AND TO COLLECT IT OUT OF THE PREMIUM FORUM, AND THEY SHOULDN'T BE ABLE TO NOT PAY BECAUSE A DOCTOR SUBMITS IT ON THE 31th DAY. THAT IS HARSH. SO MY CLIENTS ARE PRAYING AND HOPING THAT THIS COURT DOES, IN THE WORDS OF WHAT A DECEASED CIRCUIT JUDGE I LOVE BILLY WAG LETTER -- -- BILLY WAGLER, SAYS DO IT ALL.

CHIEF JUSTICE: THE COURT WILL TAKE A FIVE-MINUTE RECESS AND RECONVENE THE PANEL TO CALL THE NEXT CASE.