THE NEXT CASE IS FARREN IVEY VERSUS ALLSTATE INSURANCE.

GOOD MORNING, YOUR HONORS. MAY IT PLEASE THE COURT. I AM ROY WASON REPRESENTING THE PETITIONER, MS. IVEY, AND WITH ME MY COCOUNSEL RALPH GAMPEL. THIS IS A THIRD DISTRICT CASE WHERE ALLSTATE WAS REFUSED FROM PAYING THE FULL A THE PIP CLAIM, FOR NINE OR TEN MONTHS AFTER THE CLAIM, BECAUSE OF AN AMBIGUITY IN THE DOCTOR'S MEDICAL BILLS.

WOULD YOU ADDRESS, AT SOME LENGTH, HOW WOULD YOU DEFINE THE ESSENTIAL DEPARTURE FROM THE REQUIREMENTS OF THE LAW WHICH WOULD VEST THE THIRD DISTRICT TO BECOME INVOLVED IN THIS CASE, AFTER WE HAVE AN OPINION FROM THE CIRCUIT COURT, DESIGNED TO BE THAT THE FINAL APPELLATE COURT ON THIS PARTICULAR CASE, SINCE IT CAME FROM THE COUNTY COURT?

YES. I THINK, YOU KNOW, THE THIRD DISTRICT APPLIED THE INCORRECT STANDARD ON CERTIORARI REVIEW. THEY, IN ESSENCE, IN A FOOTNOTE CITING THIS EVERGLADES DIAGNOSTIC CASE SAID THAT THEY FOUND A MISTAKE OF LAW TO BE SUFFICIENT FOR CERT. I DON'T UNDERSTAND YOUR QUESTION.

YOU WERE DETERMINING HOW IT WAS FOUND. IT APPEARS THAT THIS REQUIREMENT OF LAW IS SO NEBULOUS THAT IT CAN BE PULLED FROM THE SKY, ANY TIME SOMEBODY WANTS TO DEAL WITH IT, SO, REALLY, WHAT IS THAT?

IN ONE OF THE CASES THAT I CITED IN OUR BRIEF, THERE IS TWO ELEMENTS, TWO VERY SIMPLE ELEMENTS, DISCREET ELEMENTS, FOR A DEPARTURE. ONE DID THE COURT APPLY THE CORRECT BODY OF LAW? THE TRIAL COURT.

AND WHAT WOULD THAT MEAN IN THIS CASE?

PIP LAW. DID IT APPLY PIP LAW? DID IT LOOK AT THE STATUTE THAT WAS APPLICABLE? THAT STANDARD IS NOT DID THE COURT BELOW APPLY THE LAW CORRECTLY BUT DID IT APPLY THE CORRECT LAW, AND SECONDLY, WAS DUE PROCESS FOLLOWED? DID THE DEFENDANT HAVE A CHANCE TO FILE AN ANSWER AND APPEAR AT TRIAL AND PRESENT ARGUMENT IN THOSE TWO THINGS HAPPENED HERE. [TECHNICAL TROUBLE] IN HOLDING THAT THERE WAS NO CONCESSION OF JUDGMENT, BECAUSE THE ORIGINAL DENIAL OF THE CLAIM WAS REASONABLE IS JUST THROWN OUT THE WINDOW, THE DOCTRINE OF LAWLER VERSUS LLOYDS, AND LOOKING AT, FIRST, THE MERIT OF THE CASE, TO SEE IF THERE WAS A CONFESSION OF JUDGMENT. YOU CAN'T LOUISIANA AT THE MERITS OF THE CASE, AT THE TIME THE LAWSUIT IS FILED, IT TO SEE IF A VOLUNTARY PAYMENT IS A CONFESSION OF JUDGMENT. OTHERWISE IN EVERY CASE, YOU ARE GOING TO BE DECIDING THE CASE ON THE MERITS AND NOT ON THE CONFESSION OF JUDGMENT ISSUE. I CANNOT THINK OF ANY WAY IN THE WORLD THAT WHAT WILLER VERSUS LLOYDS AND THE ZOMMER CASE EXISTED AGAIN. THAT YOU CAN'T GO BACK AND SAY WHO SHOULD HAVE WON THE CASE, AND IF YOU SAY THAT THE DEFENDANT SHOULD HAVE WON THE CASE, THEN CONCLUDE THAT THE PAYMENT IS NOT A CONFESSION OF JUDGMENT. IT ABSOLUTELY CANNOT -- YOU HAVE GOT TO PUT THE MERITS OUT OF YOUR MIND AND FORGET ABOUT IT AND LOOK, IF THERE WAS A NO STRINGS ATTACHED PAYMENT, UNCONDITIONAL PAYMENT, IT HAS TO BE REGARDED AS AN ADMISSION OF LIABILITY, A CONFESSION OF JUDGMENT, OR HOWEVER ELSE YOU WANT TO CHARACTERIZE IT, WITHOUT ANY REGARD TO WHO SHOULD HAVE WON ON THE MERITS AT THE BEGINNING OF THE CASE. I DON'T SEE ANY WAY AROUND THAT. ON THE MERITS, THOUGH, AND JUST TO -- FOR THE COMFORT OF THE COURT, THIS IS A -- I BELIEVE A CLEAR CASE

IN WHICH THE INSURANCE COMPANY SHOULD HAVE INVESTIGATED THE CLAIM, HAD 30 DAYS TO HAVE CALLED THE DOCTOR, IF THERE WAS AN AMBIGUITY IN THE MEDICAL BILL, WHICH EVEN ARGUABLY GAVE THEM PAUSE ABOUT PAYING 80% OF THE FULL A THE MEDICAL BILL. THEY SHOULD HAVE INVESTIGATED, AND THAT IS WHAT THE 30 DAYS ALLOWS THEM TO DO. IF DHALED THE DOCTOR'S OFFICE AND SAID -- IF THEY CALLED THE DOCTOR'S OFFICE AND SAID HOW MANY FIST YO THERAPY TREATMENTS DID YOU RENDER, HE WOULD HAVE SAID TWO EACH DAY, AS HE SAID ON DEPOSITION, BUT THEY DID NOT DO. THAT NOW, I DON'T THINK THAT THE -- IT IS NOT THAT MUCH OF AN AMBIGUITY, REALLY, BUT I THINK THAT THE RECORD SUPPORTS THE CONCLUSION THAT THE TWO PARTS OF THE BODY WERE BEING TREEED AT ALL TIMES. THE FIRST -- TREATED AT ALL TIMES. THE FIRST HEALTH CLAIM FORM BY THE INSURANCE COMPANY PUTS A DIAGNOSIS CONFUSION MODERATE LEFT LOWER LEG AND CONFUSION AND STRAIN OF THE RIGHT SHOULDER, PUTS TWO PARTS OF THE BODY, SO FOR THE INSURANCE COMPANY TO ARBITRARILY CONCLUDE THAT HE WAS ONLY TREATING ONE PART OF THE BODY, WITHOUT DOING ANY INVESTIGATION, IS UNREASONABLE.

NOW SIGNIFICANT IS IT, IF THE DOCTOR, HIMSELF, SAID THAT HIS BILL WAS A.M. BIG GUYS?

WELL -- WAS AMBIGUOUS?

WELL, HE IS SAID, AT ONE POINT, IT WAS AMBIGUOUS. HE SAID, SOMEPLACE ELSE, THAT AN ADJUSTOR, A REASONABLE ADJUSTOR REVIEWING THIS SHOULD CONCLUDE THAT IT WAS TWO PARTS OF THE BODY THAT WERE BEING TREATED, BUT IF IT WAS AMBIGUOUS, AND LET'S ACCEPT THAT IT WAS AMBIGUOUS, THAT DOES NOT DISCHARGE THE INSURANCE COMPANY FROM ITS OBLIGATION TO, WITHIN 30 DAYS, CLEAR UP THE AMBIGUITY AND PAY THE FULL AMOUNT OF THE CLAIM THAT IS OWING UNDER PIP LAW.

BUT DID THE INSURANCE COMPANY PAY, WITHIN 30 DAYS OF CLARIFICATION OF WHAT THE BILL WAS?

BUT THEY CAN'T WAIT NINE OR TEN MONTHS TO GET CLARIFICATION. THEY HAVE TO GET CLARIFICATION WITHIN THE 30-DAY PERIOD OR ELSE THEY CAN ALWAYS, ANY TIME THEY LOOK AT A CLAIM, IF IT COULD, ARGUABLY, BE READ, SOME WAY, TO FAVOR THEM, AS I SAID IN MY BRIEF, THEY COULD STICK THEIR HEAD IN THE SAND AND SAY WE ARE GOING TO READ THIS IN A WAY THAT FAVORS US AND WAIT FOR THE CLAIMANT TO COME FORWARD AND SAY, HEY, IN CASE YOU WERE WONDERING HOW MANY TIMES I WAS TREATED, IT WAS TWO PER DAY. THEY CAN'T DO. THAT UNDER THE -- UNDER MARTINEZ VERSUS FORTUNE AND PACHINKO, WHEN THEY DON'T GET THE INFORMATION THEY NEED WITHIN THE TIME, THEY HAVE TO MAKE THE FULL PAYMENT --

THEY PAID WITHIN THE THIRTY DAYS IS IN MY MIND. WHY AM I WRONG ON THAT?

FOR EXAMPLE ON DR. STRUELL'S LETTER --

THEY PAID WITHIN 30 DAYS OF HIS DEPOSITION, CORRECT?

OF HIS DEPOSITION, BUT I DON'T THINK THAT THAT WAS --

AFTER HE SAID THEY HAVE SHOWED DR. THEODORE STRUELL?

YES.

AFTER THEY SHOWED DR. STRUELL THE BILL AT THE DEPOSITION, HE SAID THAT IS FOR TWO TREATMENTS AT $27.50 APIECE, AND THEN THEY LEFT IT THAT THAT WAS SORT OF WHAT HE SAID ABOUT IT, SO THEN, SINCE THAT WAS WITHIN THE $36,, ALLSTATE PAID IT, WITHIN 30 DAYS OF HIM HAVING SAID THAT. ISN'T THAT BASICALLY WHAT OCCURRED?

THEY SHOULDN'T HAVE WAITED NINE OR TEN MONTHS TO TAKE HIS DEPOSITION.

I UNDERSTAND THAT, BUT THAT IS WHAT OCCURRED.

YES. WHEN THEY GOT HIS REPORT OF FEBRUARY 5, 1995, WHERE IT SAYS, UNDER DIAGNOSIS, THE PATIENT WAS, QUOTE, STARTED ON MULTIPLE FIST YO THERAPY TREATMENTS TO THE LEFT LOWER LEG AND THE RIGHT SHOULDER.

LET ME ASK YOU THIS. IF WE ACCEPT YOUR ARGYAUPT, THE PIP CARRIER HAS A DUTY TO INVESTIGATE. IT IS REALLY NOT FAIR TO REQUIRE THAT PLAINTIFF WOULD HAVE TO FILE SUIT AND THEN MAKE THE DOCTOR GO TO A DEPOSITION, BUT WHEN THE PLAINTIFF GETS THE MONEY, THE PLAINTIFF KNOWS TWO PARTS ARE BEING TREATED. DOES THE PLAINTIFF HAVE ANY OBLIGATION, UNDER THE STATUTE, OR UNDER CASE LAW? I MEAN IT COULD JUST CALL ALLSTATE BACK AND SAID, HEY, WHY ARE YOU ONLY PAYING THIS MUCH, AND THEY WOULD SAY, WELL, BECAUSE WE ONLY ALLOW THIS FOR, YOU KNOW, AN ONE PHYSICAL THERAPY TREATMENT A DAY, AND HE SAID I HAVE GOT TWO. CALL THE DOCTOR. OR IN OTHER WORDS I GUESS I -- THIS IDEA THAT SOMEONE JUMPS INTO THE COURTROOM CERTAINLY OR INTO THE COURTHOUSE, I MEAN, WE WANT TO DISCHURCH THAT, IN THE WAY THE PIP STATUTE WORKS AND IT ENCOURAGES PIP CARRIERS TO PAY. ON THE OTHER HAND, IS THERE ANY OBLIGATION ON THE PART OF THE CLAIMANT AT ALL, WHEN IT IS JUST, REALLY, A QUESTION THEY PAID SOMETHING OR MOST OF IT, TO CALL UP AND SAY WHY DON'T YOU PAY THE REST?

I DON'T THINK THERE IS, AND I DON'T THINK THAT THERE CAN BE. BECAUSE I THINK THAT, WHILE WE HAVE A PRETTY STABLE BODY OF PIP CARRIERS OUT THERE THAT ARE EXPERTS IN REVIEWING BILLS AND IN MAKING PAYMENT DETERMINATIONS AND IN DECIDING HOW MUCH IS GOING TO BE PAID, WE HAVE SUCH A BROAD RANGE OF CITIZENRY WHO ARE SMART OR NOT SMART OR --

BUT HERE, IN THIS CASE, IT WAS WHAT HAPPENED, ALSO, WITHIN 30 DAYS THAT JUSTICE SHAW WAS ASKING, IS THAT ALLSTATE PAID THE AMOUNT THAT WAS WITHIN THEIR GUIDELINES AND SENT IT TO THE DOCTOR, AND THE DOCTOR DIDN'T CONTEST IT. ISN'T THAT RIGHT?

HE DIDN'T. HE DIDN'T.

AND SO THAT IS, ALSO, HAPPENED WITHIN THE 30-DAY PERIOD OF THE STATUTE, THAT THE ORIGINAL AMOUNT WAS SENT TO THE DOCTOR, AND THE DOCTOR DIDN'T RAISE ANY CONTEST ABOUT IT.

AND I DON'T KNOW IF THE DOCTOR IS USED TO GETTING CHECKS IN PIECEMEAL OR THOUGHT MAYBE MORE WAS COMING DOWN THE LINE, AND I DON'T BELIEVE THAT THERE WAS ANY TESTIMONY ON WHY HE DIDN'T OR WHAT HE THOUGHT, WHEN HE GOT IT. I KNOW HE DIDN'T CALL BACK OR DO ANYTHING ELSE. [TECHNICAL DIFFICULTIES] IS ONCE WE GET INTO THAT -- ONCE WE GET INTO THAT, IT IS GOING TO RESOLVE IN A FACTUAL DETERMINATION IN EVERY CASE.

LET ME ASK YOU THIS. DID THE 30 DAYS CONTEMPLATED RUN FROM THE TIME THE BILL IS PRESENTED OR FROM THE TIME IT IS CHALLENGED?

THE TIME IT IS PRESENTED OR THE TIME WHAT?

IT IS CHALLENGED.

I THOUGHT --

AS IN THIS SITUATION HERE.

I THOUGHT WITHIN 30 DAYS THE INSURANCE COMPANY HAD TO COME UP WITH REASONABLE

PROOF THAT THEY DON'T OWE THE CLAIM, OR ELSE IF THEY DON'T, WITHIN THE 30 DAYS AFTER IT IS PRESENTED, COME UP WITH SOME REASONABLE PROOF, THEN THE MONEY IS OWED, AND HERE THEY DIDN'T PICK UP THE PHONE AND CALL THE DOCTOR, THEY DIDN'T DO ANYTHING, MUCH LESS --

WHY DIDN'T THEY COME UP WITH -- WHY WASN'T THIS A REASONABLE BASIS, IF, I ASSUME THAT THE ADJUSTOR HAS SOME KIND OF SCALE THAT HE LOOKS AT AND SAYS $25 FOR TREATING THIS PARTICULAR ARM OR LEG FOR THIS CAUSE, AND THAT IS WHAT HE LOOKED AT AND SAW ONE TREATMENT, SO HE PAID FOR ONE, WHEN, IN FACT, IT WAS TWO.

IT WAS AMBIGUOUS.

AND THE DOCTOR SAID, WELL, IT COULD BE READ TO BE AMBIGUOUS FOR THIS REASON. WHY ISN'T THAT A REASONABLE BASIS, AND WHY ISN'T THAT WHAT IS CONTEMPLATED BY ACT, TO GIVE THE INSURANCE COMPANY TIME TO CLARIFY THIS TYPE OF AMBIGUITY?

IT NOT REASONABLE PROOF THAT THEY DON'T OWE THE CLAIM. IF THERE IS AN AMBIGUITY THERE, THE AMBIGUITY, I THINK, NEEDS TO BE EITHER, A, RESOLVED IN FAVOR OF THE CLAIMANT, BECAUSE THE BILL SHOWED TWO PARTS OF THE BODY BEING TREATED, OR, B, THE BURDEN IS SHIFTED ON TO THE INSURANCE COMPANY TO GO AHEAD AND DO SOME INVESTIGATION. HAD THEY CALLED AND BEEN GIVEN SOME FALSE INFORMATION, WE DON'T HAVE THAT CASE HERE, BUT THEY DID THOUGHT DO ANYTHING -- THEY DID NOT DO ANYTHING, LIFT A FINGER TO RESOLVE THIS AMBIGUITY, WHICH I BELIEVE SHOULD BE RESOLVED IN FAVOR OF THE CLAIMANT HERE.

SO IT IS YOUR RESPONSE, THEN, TO JUSTICE SHAW'S POSITION, THAT -- JUSTICE SHAW, THAT THEY HAD 30 DAYS TO RESOLVE THE AMBIGUITY.

NOTHING WAS DONE. THEY 30 DAYS HERE. I AM INTO MY REBUTTAL TIME, BUT AS TO THE REVIEW --

BEFORE YOU CLOSE, DOES THE INSURANCE COMPANY SEND ANYTHING WITH THE CHECK, ANY KIND OF EXPLANATION AS TO HOW THEY GOT TO THAT AMOUNT?

NO. I DON'T BELIEVE SO. I DON'T BELIEVE SO.

WELL, THEY SENT THE AMOUNT TO THE DOCTOR. RIGHT?

RIGHT. THEY SENT THE AMOUNT TO THE DR. AND THE DOCTOR, I AM SURE, ALONG WITH DOZENS OR HUNDREDS OF OTHER CHECKS FROM OTHER PATIENTS, GETS THEM IN AND --

DID THE DOCTOR EVER TRY TO GET THE ADDITIONAL AMOUNT FROM THE CLAIMANT?

NEVER D NEVER DID. NO.

JUST ON THE -- JUST ON THE STANDARD OF REVIEW HERE, UNLESS WE APPLY THE CERT STANDARD HERE, IT IS, REALLY, GIVING TWO APPEALS ON THE MERITS OF THIS CASE FORM THE CIRCUIT COURT APPELLATE PANEL THOUGHT LONG AND HARD AND WROTE A GOOD OPINION. THE THIRD DISTRICT IS, IN ESSENCE, SUBSTITUTING ITS JUDGMENT ON THE MERITS OF THE DECISION AND THAT IS NOT THE APPLICABLE STANDARD OF REVIEW ON CERTIORARI, SO WHETHER THIS COURT AGREES ON THE STANDARD OF REVIEW OR NOT, IT SHOULD QUASH AND KEEP THE STANDARD OF INTEGRITY OF REVIEW ON CERTIORARI. I ASK YOU TO QUASH FOR ANY ONE OF THREE REASONS. THANK YOU.

MR. SHERMAN.

YOUR HONORS, RICHARD SHERMAN FOR THE APPELLEE. GOING TO, I GUESS, YOUR QUESTION, FIRST, ABOUT JURISDICTION, I THINK THAT THERE IS A TWO WAYS OF LOOKING AT IT AS TO WHETHER THERE IS JURISDICTION. FIRST OF ALL, IF THIS IS A PURELY FACTUAL ISSUE, THEN THE CIRCUIT COURT, SITTING IN ITS APPELLATE CAPACITY, SUBSTITUTED ITS VIEW OF THE FACTS FOR THE TRIAL COURT, AND THEREFORE IT DEVIATED FROM THE ESSENTIAL REQUIREMENTS OF THE LAW, SO THERE WAS JURISDICTION TO REVIEW THAT. HOWEVER, IF IT IS A PURELY LEGAL MATTER, THEN THE THIRD DISTRICT CAN REVIEW IT, BECAUSE IF THE APPELLATE COURT GETS THE WRONG LAW, THEN THEY DEVIATE FROM THE CENTRAL REQUIREMENTS OF THE LAW, SO I THINK NO MATTER WHICH WAY WE LOOK AT IT, WHETHER IT IS FACTUAL OR A LEGAL ISSUE, THEN THERE IS JURISDICTION, BECAUSE --

IS THERE REALLY LAW ON THE AREA THAT IS WHERE THE CARRIER, THE INSUROR PAYS MOST OF THE CLAIM, DOESN'T PAY ALL OF THE CLAIM, WHETHER THE DUTY TO INVESTIGATE EXTENDS TO PAY -- TO FIND OUT WHY THE BILL WAS THIS MUCH AND TO CHECK TO MAKE SURE THAT THEIR FACTS ARE OKAY? IN OTHER WORDS THAT THE DUTY TO INVESTIGATE EXTENDS? IS THERE A LAW ON THIS SUBJECT?

THIS IS THE FIRST, THE ONLY CASE ON THIS ISSUE, AND --

SO HOW COULD THE CIRCUIT COURT BE WRONG ON THE LAW, IF THERE WAS NO LAW ON THE ISSUE?

WELL, THEY INTERPRET THE STATUTE, WOULD BE THE WAY, AND I THINK THE OTHER THING IS THE POINT YOUR HONOR MADE IS THAT, AS A PRACTICAL MATTER, THE APPELLATE COURTS NEED TO BE ABLE TO REVIEW THE CIRCUIT COURTS SITTING IN THEIR APPELLATE CAPACITY, BECAUSE THEY ARE NOT REALLY EQUIPPED TO DECIDE, APPELLATE CASES, TO DECIDE ISSUES OF LAW. THEY DON'T HAVE THE STAFF. THEY ARE NOT GEARED FOR READING 100 PAGES OF BRIEFS AND 50 PAGES OF CASE LAW, AND THE PRACTICALITY, YOU GO AND ARGUE A CASE BEFORE THEM, AND YOU KNOW, IT IS LIKE A HEARING. THEY SAY, ALL RIGHT, NOW, TELL ME WHAT THIS CASE IS ABOUT. EVERYBODY FILED ALL OF THESE BRIEFS AND THEY SIT THERE, NOW, AND WHAT IS THIS CASE ABOUT, AND GENERALLY AT THE END OF THE HEARING THEY MAKE A RULING. SO THEY ARE NOT --

THAT DIDN'T HAPPEN IN THIS CASE. THIS COURT WAS A THREE-JUDGE PANEL FROM THE ELEVENTH CIRCUIT THAT ISSUED A FOUR-PAGE WRITTEN OPINION, WITH CASE LAW SUPPORTING IT.

BUT, YOUR HONOR, THAT DOESN'T MEAN THAT THEY HAD READ THE BRIEFS AND THE CASES BEFORE THE HEARING, AS A PRACTICAL MATTER. THEY ARE NOT GEARED TO DOING THE INTELLECTUAL WORK, LIKE THE APPELLATE JUDGES ARE.

SO YOU ARE SAYING THAT AT ANY TIME EITHER PARTY DOESN'T LIKE THE DECISION, THAT IT IS REALLY OKAY FOR THE APPELLATE COURT TO REVIEW IT, BECAUSE THEY ARE REALLY BETTER EQUIPPED TO DO APPELLATE WORK, AND SO DOESN'T THAT REALLY SPEAK VERY BADLY OF THE WHOLE SYSTEM THAT WE CURRENTLY HAVE IN EFFECT? ARE YOU ASKING US TO CHANGE THAT SYSTEM?

I AM SAYING, AS A PRACTICAL MATTER, A POINT YOUR HONOR MADE, IS THAT THE REVIEW, THE DISCRETIONARY REVIEW OF THE APPELLATE COURT SHOULD BE GIVEN MORE WIDE LATITUDE, BECAUSE THEY DO NEED TO CLARIFY THE LAW.

IS THERE A PROCEDURE FOR CERTIFYING, FOR THE CIRCUIT COURTS TO CERTIFY QUESTIONS OR TO REQUEST THAT THEY CERTIFY QUESTIONS, LIKE THE COUNTY COURT CAN DO?

I DON'T BELIEVE THE CIRCUIT COURTS CAN CERTIFY CASES. I DON'T BELIEVE THERE IS A PROVISION. I MEAN I THINK THAT, AT TIMES IT WOULD BE GOOD, AND I THINK ANOTHER THING, IT WOULD BE GOOD, THE COUNTY COURTS CAN ONLY CERTIFY FINAL JUDGMENTS. THEY CAN'T CERTIFY CASES ON INTERLOCUTORY APPEALS, AND THERE ARE A LOT OF ISSUES THAT COUNTY COURTS TRY TO DO IT AND WE CAN'T GET IT UP, SO I THINK IT WOULD BE GOOD TO HAVE THAT.

YOU ADMIT YOU USED THIS CASE FOR A SECOND APPEAL. THIS DOESN'T FIT INTO THE DEPARTURE FROM THE ESSENTIAL REQUIREMENTS OF LAW OR A MISCARRIAGE OF JUSTICE, AS THIS COURT HAS USED THAT TERM, IN CASES WHERE DEFINING THE LIMITED REVIEW, CERT, THAT --

I THINK THAT THE THIRD DISTRICT, AS THIS COURT, I AM SURE, KNOWS, THERE ARE TENS OF THOUSANDS OF PIP CASES FILED THAT ARE CLOGGING THE COUNTY COURTS, AND YOU CAN'T, ON JUST ABOUT THREE SIMPLE ISSUES, AND YOU CAN'T GET AN APPELLATE DECISION, BECAUSE THEY GO TO CIRCUIT COURT, AND SO I THINK THE THIRD DISTRICT SAID, GIVEN THE IMPORTANCE OF PIP CASES AND THE AUTOMOBILES AND PIP COVERAGE, THAT WE OUGHT TO GET AN APPELLATE DECISION, AND SO I THINK THAT IS WHAT THEY DID. SO I THINK ON --.

WOULD YOU, ALSO, ADDRESS -- LET'S TAKE A SCENARIO THAT THERE IS SOMEONE THAT IS INJURED IN AN INCIDENT, AN INTERNAL INJURY, AND IT CAUSES, MAYBE, AN APPENDECTOMY, BUT DURING THAT PROCEDURE THE INTESTINE RUPTURES, AND IT TAKES MORE TIME AND THEY SEND THE MEDICAL BILL IN AND IT IS AN APPENDECTOMY. THE BILL COMES IN, $1500, AND BECAUSE THE COMPANY HAS A POLLY OF ONLY PAYING $1,000, THEY SEND OUT THE THOUSAND, SAYING GO O WHERE WOULD THAT COME IN? WHO HAS THE OBLIGATION, UNDER THAT KIND OF CIRCUMSTANCES, WHERE THERE IS SOME UNCERTAINTY ABOUT THE EXTENT OF THE SERVICES? WHO HAS THE OBLIGATION AND WITHIN WHAT PERIOD OF TIME, AND WHERE IS THE POLICY THAT WE SHOULD APPLY? SHOULD WE FORCE INSURORS TO GET A LAWYER TO CLARIFY THIS ARE OR SHOULD IT BE AN OBLIGATION WITHIN 30 DAYS? I AM HAVING THAT TROUBLE.

INC. THAT IS EXACTLY THE SITUATION THAT THE STATUTE IS DESIGNED. THAT IF THE COMPANY SAYS THIS IS ALL -- THE BILL IS CLEAR. THIS IS WHAT WE CHARGE. WE DID. THIS IS WHAT WE CHARGE. THEN THE CARRIER MAKES A DECISION. DO WE PAY THAT AND RISK GETTING HIT WITH ATTORNEYS FEES OR DO WE -- I MEAN, WE DENY IT AND RISK IT OR DO WE GO AHEAD AND PAY?

ON ITS FACE, THIS BILL WAS CLEAR, THAT IT WAS $55. THE CARRIER TOOK THE UNILATERAL POSITION THAT THAT IS TOO MUCH. I MEAN THAT IS BASICALLY --

IT IS CLEAR ON ITS FACE THAT IT WAS FOR ONE UNIT PER TREATMENT.

LET'S GO BACK. IT WAS $55 FOR WHATEVER IT WAS. CALL IT WIGE ITS, IF YOU WANT. -- WIGITS, IF YOU WANT, AND THE CARRIER DECIDED THAT WAS TOO MUCH, SO THEY SENT OUT LESS TO THE DOCTOR. IT WAS ONLY LATER THAT THEY SAID IT WAS FOR MORE, SO WE DID OWE IT. THAT IS WHAT I AM HAVING A DIFFICULT TIME WITH. IT IS CLEAR ON ITS FACE THAT IT IS $55. IT IS THE INSURANCE COMPANY THAT MADE THE DECISION TO UNION LATLY REDUCE IT.

THE -- TO UNILATERALLY REDUCE IT.

THE PIP --

TO MAKE THE DECISION BUT IT WAS MADE BY THE COMPANY UNILATERALLY.

WE ARE TAKING A RISK. THIS IS WHAT WE DETERMINED WAS REASONABLE. IF THEY WANT TO FILE SUIT, THEN WE GO TO COURT, AND IT IS US AND THE DOCTOR TO DETERMINE WHAT IS A REASONABLE CHARGE, BUT THEY ARE ON NOTICE AS TO WHAT THE CHARGE IS, AND THIS, ALL SEVEN CHARGES RESPECT AND I DON'T THINK IT IS AMBIGUOUS AT ALL. IT SAYS UNIT. ONE UNIT. $55. AND THIS IS VERY, VERY IMPORTANT, AND A POINT THAT HAS BEEN GLOSSED OVER. THEY

SAY THAT YOU CAN LOOK AT THE BILL AND KNOW HE IS BEING TREATED FOR TWO PARTS. NOW, LISTEN TO THIS, AND ESPECIALLY THE SECOND. CONTUSION AND SPRAIN RIGHT SHOULDER. OKAY. SPRAIN. CONTUSION MODERATE LEFT LOWER LEG. NOW, WHO WOULD THINK THAT THEY ARE DOING ELECTRICAL STIMULATION FOR A BRUISE? I MEAN SEVEN DAYS OF ELECTRICAL STIMULATION? SO I DON'T THINK IT IS AT ALL AMBIGUOUS.

WHAT IS WRONG WITH THE IDEA THAT ALL THE CARRIER HAS TO DO, THEY HAVE GOT THE SCHEDULE OF WHAT THEY ARE GOING TO PAY. THEY MAKE A DECISION WHAT THEY ARE GOING TO PAY. THEY ARE DOING THIS EVERYDAY. PICK UP A PHONE. THEY HAVE GOT 30 DAYS. THEY DIDN'T SAY THEY DIDN'T HAVE ENOUGH TIME TO INVESTIGATE. AND CHECK AND SAY WHY DID YOU CHARGE $55? WE ONLY PAY $36 FOR ONE MODALITY OR ONE TREATMENT. RATHER THAN, I MEAN, IT SEEMS LIKE THAT IS A MUCH BETTER POLICY. WHAT DOES ALLSTATE WANT TO GET IN THERE AND HAVE TO PAY ATTORNEYS FEES AND GO THROUGH THIS KIND OF SITUATION AND HAVE LAWSUITS AND CLOG UP THE COUNTY COURTS, AS YOU SAY, WITH THESE KINDS OF CASES?

THE ANSWER TO YOUR QUESTION IS THERE WAS AN ACCURATE ANSWER TO JUSTICE QUINCE'S QUESTION. SHE ASKED IF AN EXPLANATION WAS SENT AND THEY WERE TOLD NO. AN EXPLANATION WAS SENT AS TO HOW THE PAYMENT WAS ARRIVED AT. SO --

WHERE IS THAT IN THE RECORD? THAT THERE IS AN EXPLANATION SENT, PLEASE. I DIDN'T FIND THAT.

I KNOW WE CITED IN OUR BRIEF, AND I WILL HAVE TO -- I DON'T KNOW THE CITATION. I KNOW WE DEFINITELY DID CITE IT IN A BRIEF.

THAT'S ALL RIGHT.

WAS IT SENT TO THE DOCTOR?

YES.

IT IS NOT THE DOCTOR -- THE DOCTOR DIDN'T BRING THIS LAWSUIT.

NO. THAT'S THE OTHER THING. THE DOCTOR, WRITES IT OFF. ALL RIGHT. THAT IS FINE. AND NOBODY IS GOING AGAINST THE PLAINTIFF, AND THEY JUST BRING IT FOR ATTORNEYS FEES. THAT IS ALL THESE CASES ARE ABOUT.

THE PLAINTIFF, IF THE DOCTOR, DO WE KNOW WHAT HAPPENED? THE DOCTOR CALLED AND SAID YOU OWE THE REST?

NO. NO. THE TESTIMONY OF THE DOCTOR SAID NO. HE MADE NO ADEPT TO COLLECT IT FROM THE PATIENT. AND --

DID -- HE MADE NO ATTEMPT TO COLLECT IT FROM THE PATIENT.

DID HE WRITE IT OFF? IS THAT A LEGAL LIABILITY OR DOES IT NO LONGER EXIST? IT IS GONE.

I GUESS IT IS ONE OF THOSE THINGS THAT THEORETICALLY EXISTS FOR FIVE YEARS, BUT HE SAID HE DID NOT ATTEMPT TO COLLECT IT AND DID NOT HAVE ANY INTENTION OF IT.

DID I UNDERSTAND YOU TO SAY THAT YOU DID NOT FIND THE BILL AMBIGUOUS?

THAT'S CORRECT.

SO IT IS ALLSTATE'S POSITION THAT THE BILL WAS NOT AMBIGUOUS. IS THAT CORRECT?

RIGHT. IT SAYS ONE UNIT OF TREATMENT, AND YOU KNOW, LIKE I SAID, THEY ARE SAYING IT IS AMBIGUOUS, BECAUSE -- I MEAN, ONCE AGAIN, CONTUSION OF THE LEFT LOWER LEG. I MEAN HOW WOULD -- WHO WOULD THINK A DOCTOR WOULD GIVE SEVEN ELECTRICAL STIMULATION TREATMENTS FOR A BRUISE? SO I DON'T THINK THERE IS ANY AMBIGUITY. YOU HAVE -- THIS IS THE STANDARD --

AMBIGUITY. THE BILL SAYS, WHAT, $55 OR WHATEVER IT IS.

$55 FOR ONE UNIT. YOU ARE RIGHT. AND ALLSTATE PAYS MORE FOR ONE UNIT THAN THE DOCTOR CHARGES. THE DOCTOR'S NURSE SAID THAT THEY NEVER PUT HOW MANY UNITS ON IT, AND SO THAT IS THE WHOLE THING IS THE DOCTOR IS, YOU KNOW, DONE USED COMPUTER BILLING AND DONE PUT THE NUMBER OF UNITS ON IT, AND THEY ARE ENTITLED TO GO BY THE BILL AND SEE IF IT IS, YOU KNOW, A PROPER AMOUNT FOR, YOU KNOW -- THAT IS PART OF THE PIP STATUTE. THEY DON'T WANT DOCTORS OVERBILLING THE SYSTEM AND THAT COSTS --

WHAT HAPPENED HERE WAS THAT THE ALLSTATE ADJUSTOR REVIEWED THIS BILL. CONCLUDED THAT IT WAS $55. ALLSTATE'S STANDARD WAS TO PAY $36. SO THEY CHECK -- A CHECK WAS SENT FOR THAT AMOUNT?

THAT'S CORRECT.

PER VICE SNIT.

THAT'S CORRECT.

OR WAS IT -- PER VISIT?

THAT'S CORRECT. AND COUNSEL DIDN'T REALIZE THAT IT WAS FOR TWO. DURING THE DOCTOR'S DEPOSITION, HE LOOKED AT IT AND SAID OH, NO, THAT IS A MISTAKE. THAT IS FOR TWO UNITS. THAT CAUGHT THE ATTORNEY BY SURPRISE AND CAUGHT EVERYBODY BY SURPRISE, AND THE DOCTOR SAID I WILL GO BACK AND SEND A BILL THAT SHOWS TWO UNITS, SO THEY DID IT AND WITHIN 30 DAYS OF THE DPEPINGS, IT WAS PAID.

SO -- OF THE DEPOSITION, IT WAS PAID.

SO DR. STRUELL, THEN, CAME BACK AND SENT A BILL FOR THE NET BALANCE. IS THAT BILL ON THE RECORD?

HE SAID I AM GOING TO GO SEND A BILL FOR THE BALANCE, AND IT WAS PAID WITHIN 30 DAYS OF THE DEPOSITION. I DON'T KNOW IF THEY WAITED TO GET THE BILL TO DO IT OR WHETHER THEY --

IS THAT BILL IN THE RECORD?

I AM NOT AWARE OF IT. SO YOU KNOW, YOUR HONOR, I THINK, AND ANOTHER POINT, THING I WANT TO POINT OUT, IS THAT THIS WON'T HAPPEN AGAIN, BECAUSE THE LEGISLATURE EFFECTIVELY HAS CHANGED THIS, TO DO LEGISLATIVELY WHAT THE THIRD DISTRICT DID, APPLYING COMMON SENSE. 627.36 AND SECTION 6-B, CHANGED THE LAW SO THAT IF, WITHIN WHEN THE CARRIER GETS THE BILL, THEN, WITHIN 20 DAYS, IF THEY ASKED FOR MEDICAL REPORTS, THEN ONCE THEY GET THEM, THEY HAVE AN ADDITIONAL TEN DAYS, SO UNDER THE PRIOR STATUTE, WHEN IVEY WAS IN EFFECT, IT WAS THE PACHICKO, THE MARTINEZ CASES, THAT THEY HAD TO PAY WITHIN 30 DAYS OF RECEIVING THE BILL. THEY COULDN'T TOLL THE TIME FOR VERIFICATION. THE LEGISLATURE HAS CHANGED THAT TO SAY NOW, IF THEY DO, THAT DOES TOLL THE TIME.

SO IN THIS SITUATION, THEY SAY TO THE DOCTOR WE HAVE A QUESTION ABOUT WHY YOU

CHARGE $55. SEND US A REPORT. IS THAT WHAT WOULD HAVE OCCURRED?

WELL, RIGHT.

IN OTHER WORDS IT STILL PUTS THE BURDEN ON THE INSURANCE COMPANY TO FIND OUT WHY THE CHARGE IS WHAT IT IS AND THEN TO DO SOMETHING ABOUT IT, ONCE THEY GET THE INFORMATION.

I THINK THE BOTTOM LINE IS YOU KNOW, YOU CAN RELY ON THE BILL AND WHAT IT SAID. IF IT SAYS IT IS FOR ONE UNIT, YOU CAN RELY THAT IT IS ONE UNIT.

HOW WOULD THIS NEW LAW CHANGE THE CASE? THEY DIDN'T HAVE FOR MEDICAL RECORDS.

I AM SAYING THAT ALL THE LITIGATION SO FAR HAS GONE, AND THEY ARE ARGUING THAT THE CARRIER MUST PAY ANY BILL WITHIN 30 DAYS OF GETTING THE BILL, REGARDLESS.

I THINK WE ARE ARGUING THAT, WHEN THERE IS A QUESTION AND YOU ARE NOT GOING TO PAY THE FULL BILL, THAT YOU HAVE SOME OBLIGATION, UNDER THE PIP STATUTE, TO INVESTIGATE WHY THAT BILL WAS WHAT IT WAS, AND THAT ALLSTATE, IN THIS CASE, DID NOTHING.

WELL, YOUR HONOR, RELYING ON THE FACE OF THE BILL IS THE WHOLE THING. THEY ARE SAYING, WAIT. WE SHOULD HAVE GONE BACK AND READ THE MEDICAL RECORDS, AND IF THEY HAD, THEY WOULD HAVE SEEN THE RECORDS, BUT ON THE BILL IT SAYS FOR ONE UNIT, AND I THINK MODERN BUSINESS, WHEN YOU GET A BILL, YOU CAN RELY ON WHAT IT SAYS ON THE FRONT OF IT FOR ONE UNIT, SO I THINK THAT IS THE REAL KEY THING. I THINK AN ATTORNEY HAS AN OBLIGATION TO INVESTIGATE A CASE BEFORE HE EVER FILES SUIT. HE DIDN'T KNOW IT WAS FOR TWO UNITS, ANYMORE THAN ANYBODY ELSE DID. THE PIP STATUTE SAYS YOU ONLY PAY REASONABLE CHARGES. THEY DON'T WANT DOCTORS RUNNING UP INSURANCE BILLS BY OVERBILLING THE SYSTEM, AND SO THAT IS THE PUBLIC POLICY THAT IS INVOLVED.

ISN'T THE POLICY THAT IT IS UP TO THE PIP CARRIER TO DECIDE THE FIRST BLUSH WHAT IS REASONABLE, BUT IF THEY ARE WRONG, THEY HAVE GOT TO PAY THE FREIGHT. ISN'T THAT WHAT THE STATUTE IS DESIGNED --

THAT'S CORRECT, BUT THEY CAN RELY ON THE BILL TO SEE IF IT IS REASONABLE OR NOT. THAT IS THE WHOLE --

THAT IS YOUR LAW. I MEAN, THAT IS WHAT THE THIRD DISTRICT, WERE THEY SAYING THE BILL WAS CLEAR AND THEY COULD RELY ON THE BILL BECAUSE IT IS CLEAR, OR ARE THEY SAYING THAT THE BILL WAS AMBIGUOUS, AND THEY DIDN'T HAVE TO -- THEY DIDN'T HAVE TO PAY UNTIL THEY FOUND OUT WHY?

RIGHT. THEY ARE SAYING DR. STRUELL, ONCE HE INDICATED THAT THE BILL ONLY SAID ONE UNIT, AND WE QUOTE HIS TESTIMONY IN OUR BRIEF. IT WAS ONE UNIT AND, IN FACT, IT WAS TO UNITS. ONCE THEY FOUND OUT IT WAS TWO UNITS, SO I THINK ALLSTATE ACTED REASONABLY, AND ANY WAY, YOU GET A BILL IN FOR YOUR CAR OR WHATEVER AND YOU LOOK AT IT, AND YOU SEE IF IT SAYS FOR ONE UNIT OR THIS ONE OR TWO OR HOWEVER MANY, YOU HAVE A RIGHT TO RELY ON IT WHEN YOU ARE PAYING THE THING. SO THAT IS THE WHOLE POINT. THIS WOULD GIVE DOCTORS AN INCENTIVE TO SEND OUT INCORRECT BILLS. I MEAN, WHAT IF THERE HAD BEEN, YOU KNOW, THREE UNITS? IF YOU READ THROUGH THE MEDICAL REPORT, YOU WOULD FIND OUT THEY HAVE, ALSO, FORGOT TO CHARGE FOR SOMETHING ELSE ON THE FRONT OF THE BILL. I MEAN YOU KNOW, THIS WOULD GIVE INCENTIVE FOR DOCTORS TO SEND OUT INCORRECT BILLS AND THEN HIS BUDDY, THE ATTORNEY, THEN SUES AND GETS ATTORNEYS FEES. BECAUSE YOU HAVE A RIGHT TO RELY ON WHAT IS SAID ON THE FACE OF THE BILL.

WHAT HAPPENS IF THIS IS, INDEED, IF IT HAD, IN FACT, BEEN ONE UNIT? AND THEY HAVE THIS SCHEDULE THAT SAYS $36 AND THE DOCTOR CHARGED 55. WHAT DOES THE PLAINTIFF DO, ASSUMING THE DOCTOR IS GOING TO BILL THE PLAINTIFF FOR THE REST OF IT? WHAT DOES THE PLAINTIFF DO?

FILE SUIT AGAINST THE CARRIER?

GENERALLY THERE HAS BEEN ASSIGNMENT OF BENEFITS OVER TO THE DOCTOR, SO THE DOCTOR HAS ALL OF THE RIGHTS TO GO FORWARD WITH THE SUIT. THAT IS ONE OF THE THINGS, IN ALL OF THE PIP CASES, AND IT IS EMBODIED IN THE STATUTE, IS THAT THEY DO ASSIGNMENT OF BENEFITS OVER TO THE DOCTOR OR MEDICAL PROVIDER, AND SO GENERALLY, THE PATIENT IS REALLY OUT OF THE BILLING THING ALL TOGETHER. SO THAT IS THE SITUATION HERE.

EVEN IF WE LOOK TO THE BILL, ITSELF, AND I WAS TRYING TO SEE THE COPY IN THE RECORD, I THINK, ONLY HAD THE FACE SHEET, BUT IT TALKS IN TERMS OF DAYS OR UNITS. DOES IT EVER DEFINE UNITS? DOES IT EVER -- IS THERE SOMETHING ON HERE BEYOND THAT? THAT COULD BE ON THAT DAY WE HAD ONE DAY OF TREATMENT.

THIS IS THE STANDARD HEALTH INSURANCE CLAIM FORM, AND ALL OF THAT, THE HICKSA FORM AND ALL OF THAT.

DOES IT TELL SOMEPLACE ON THAT, THAT THAT UNIT MEANS ONE THING WAS DONE? I AM TRYING TO UNDERSTAND IT.

I DON'T THINK THERE IS ANY INSTRUCTIONS ON THE BILL, BUT THAT IS CUSTOM FOR DESCRIBING, IT IS A BILLING FORM TO DESCRIBE WHAT THE TREATMENT IS.

BUT IT SAYS DAYS AND UNITS, AND IT MATCHES DAYS.

YOU KNOW, THAT WAS NEVER CLARIFIED, BUT I MEAN, IT APPEARED THAT IT IS TREATED AS AN UNIT. BUT, YOU KNOW, I JUST THINK THAT IT IS AN UNREALISTIC BURDEN TO SAY, WHEN SOMEBODY GETS A BILL THAT SHOWS ONE THING ON THE FACE THAT, YOU KNOW, YOU CAN'T GO BY. THAT THAT YOU HAVE GOT TO GO BACK INTO THE MEDICAL RECORDS, AND I THINK ONCE AGAIN, YOU KNOW, ALLSTATE DID EVERYTHING THAT THEY ARE CHARGED FOR ONE UNIT WAS MORE THAN THE DOCTORS. IT WAS JUST AN INCORRECT BILL, AND ONCE THEY GOT IT, THEY PAID IT, SO I THINK THERE IS NO WRONGFUL DENIAL. THEY OPERATED, BASED ON THE BILL THEY GOT, AND WHEN THEY GOT THE CORRECTED, YOU KNOW, FOUND OUT IT WAS TWO UNITS, THEY PAID IT. THEY DID EVERYTHING THEY COULD. I MEAN I DON'T KNOW THAT A CARRIER HAS AN OBLIGATION TO DO ANYMORE. YOU -- THE LEGISLATURE WANTS BILLS PAID QUICKLY AND WANTS CLAIMS PROCESSED QUICKLY AND, YOU KNOW, ANY BUSY OFFICE ENVIRONMENT, YOU GET A BILL. YOU LOOK AT THE FACE OF IT, AND THEY ACTED CORRECTLY, BASED ON THE BILL THAT WAS SENT. IF THERE WAS ANY ERROR, IT WAS BY THE DOCTOR AND HIS STAFF SAID, NO, WE DON'T PUT THE NUMBER OF UNITS.

SO THE RULE WOULD BE THAT, IF THE DOCTOR MAKES AN ERROR IN THE BILLING, THAT THERE IS NO DUTY TOY INVESTIGATE, ON THE PART OF THE -- DUTY TO INVESTIGATE, ON THE PART OF THE INSURANCE COMPANY, BUT IF, IN THIS CASE, THE DOCTOR'S OFFICE HAD CALLED AND SAID -- AND QUESTIONED IT AND THEY HAD, THEN, FOUND OUT THAT IT WAS FOR TWO UNITS, THEN THEY WOULD HAVE HAD THE OBLIGATION TO PAY?

OH, SURE. DEFINITELY.

BUT AS SOON AS ALLSTATE KNEW IT WAS FOR TWO UNITS, WHENEVER THAT HAPPENED, THEY WOULD HAVE TO PAY?

RIGHT.

AND I GUESS WHAT I AM STILL HAVING TROUBLE WITH IS THAT THEY LOOKED AT THIS AND SAW THE BILL. WHY SHOULDN'T THE BETTER POLICY ABOUT THAT POLICY BE THAT THEY PICK UP THE PHONE AND FIND OUT WHY THE BILL IS THE AMOUNT THAT IS STATED, RATHER THAN JS --

THEYENT -- RATHER THAN JUST --

THEY SENT AN EXPLANATION, AND THE TRIAL JUDGE SAID THE PHONE WORKS BOTH WAYS. THEY SENT THE PAYMENT. THE EXPLANATION. WHY DIDN'T THE DOCTOR'S OFFICE CALL AND SAY THIS WAS TWO TREATMENTS? THANK YOU, YOUR HONORS.

THANK YOU. MR. WASON.

JUSTICE LEWIS HIT THE NAIL ON THE HEAD, WHEN HE POINTED OUT THAT THE MEDICAL BILL SAYS DAYS OR UNITS, AND I KNOW COUNSEL IS JUST BEING AN ADVOCATE HERE, BUT THE RECORD, I THINK, IS CLEAR THAT THE DOCTOR INTENDED THAT ENTRY TO BE NUMBER OF DAYS OF TREATMENT NOT UNITS. HE WAS ASKED, IN HIS DEPOSITION, AT PAGE 38, IF HIS BILL WAS $55 PER UNIT. NO. $55 FOR ONE DAY. IT SAYS DAYS OR UNITS. DID YOU FORGET TO WRITE DAYS IN? AND THEN ETCHES ASKED ELSEWHERE IF HIS MEDICAL BILL WAS FOR TREATMENT TO ONE PART OF THE BODY OR FOR TWO OR ONE UNITS, AND HE ANSWERED, ON PAGE 41 OF THE TRIAL TRANSCRIPT. IT IS RIGHT THERE ON THE YELLOW SHEETS. ANYBODY WHO KNOWS THAT, IF THEY HAVE HALF A BRAIN, WOULD KNOW THAT. WHY WOULD I WRITE IT THAT WAY? IT SAYS SPECIFICALLY LEFT LOWER LEG AND RIGHT SHOULDER. THE DOCTOR IS SAYING HE MEANT ONE DAY, TWO AREAS OF THE BODY MUCH TWO UNITS. IT IS, AT THE VERY LEAST, VERY, VERY AMBIGUOUS.

DID THE DOCTOR TAKE ASSIGNMENT OF THE MEDICAL BILLS?

NO, JUSTICE, HE DID NOT.

WAS THERE -- BUT I TAKE IT, FROM THIS RECORD, THAT THE DOCTOR NEVER SENT AN OVERDUE NOTICE.

IT IS NOT IN THE RECORD. I DON'T KNOW OF ANY. I DON'T KNOW OF ANY. IN CLOSING --

REALLY THE ISSUE -- THE LANGUAGE OF THE IT STATUTE IS -- OF THE STATUTE REVOLVES AROUND WHEN A BILL BECOMES OVERDUE. THAT IS THE LANGUAGE THAT IT USES. RIGHT?

WELL, I HADN'T FOCUSED ON THAT PART OF THE LANGUAGE, YOUR HONOR. I DON'T KNOW. I THOUGHT THAT THE BILL WAS OVERDUE WHEN THE -- WHEN 30 DAYS PASSED AFTER THE BILL HAD BEEN PRESENTED AND HERE THE BILL HAD BEEN PRESENTED IN A FORM THAT SHOULD HAVE PUT ALLSTATE ON NOTICE THAT THERE WAS TWO UNITS OF TREATMENT ON EACH DAY, SO I THOUGHT THAT IS WHEN IT BECAME OVERDUE, WHEN THE TIME PASSED. IN CLOSING, ON THE STANDARD OF REVIEW ISSUE, I HEARD COUNSEL BASICALLY ARGUE THAT THE STANDARD FOR CERTIORARI OR FOR CERT OUGHT TO BE LOSER IN A PIP CASE, BECAUSE YOU NEED TO HAVE THEM DECIDED IN THE DISTRICT COURT OF APPEAL, AND I WOULD SUBMIT TO THE COURT THAT THAT WOULD BE A BIG MISTAKE AND WE HAVE TO, I THINK, FOCUS IN ON THE POLICY, AN OBJECTIVE OF FLORIDA MOTOR VEHICLE NO FAULT LAW AS THIS COURT HAS HELD IS TO PROVIDE PERSONS INJURED IN AN ACCIDENT WITH PROMPT PAYMENT OF BENEFITS, SO WHEN YOU ARE DECIDING WHETHER TO CHANGE THE CERTIORARI STANDARD TO ACCOMMODATE PIP CASES, IF YOU ARE GOING TO CHANGE IT IN SUCH AWAY TO ADD A LAYER OF APPELLATE REVIEW AND FURTHER DELAY THE PAYMENT OF PIP BENEFITS, I THINK THAT IS CONTRARY TO THE PUBLIC POLICY AND THE REASON BEHIND FLORIDA PIP LAW, AND IT IS A CONSIDERATION, I BELIEVE, THAT WOULD REQUIRE A CONTINUED NARROW READING OF PIP JURISDICTION, AND QUASH THE THIRD DISTRICT

FOR REREVIEWING THE CASE AND ADDING ANOTHER LAYER OF APPEALS IN THIS CASE. UNLESS THERE IS ANY QUESTIONS, I WILL CLOSE AND ASK THAT THE THIRD DISTRICT COURT BE QUASHED.

THANK YOU. THANKS TO BOTH OF YOU.