IN THE CIRCUIT COURT OF THE THIRTEENTH JUDICIAL CIRCUIT OF THE STATE OF FLORIDA, IN AND FOR HILLSBOROUGH COUNTY CIVIL DIVISION

AFO IMAGING, INC., as assignee, individually, and on behalf of all those similarly situated,

Plaintiff,

vs.

PEAK PROPERTY AND CASUALTY INSURANCE CORP., et al.,

Defendants.

_____/

CLASS REPRESENTATION

Case No.: 08-CA-021533

Division: C

Consolidated with *AFO Imaging, Inc. v. Nationwide Mutual Fire Insurance Company, et al.,* Case No. 08-CA-021531

ORDER ON COMPETING MOTIONS FOR SUMMARY JUDGMENT

THIS CAUSE came before the Court on October 6, 2009, November 23, 2009, and December 22, 2009 concerning: (1) the "Motion for Partial Summary Judgment" filed by Plaintiff AFO Imaging, Inc. (the "**MRI Provider**"), as assignee, individually, and on behalf of all those similarly situated; and (2) the "Joint Motion for Summary Judgment" filed by the Defendants, Nationwide Mutual Fire Insurance Company, Nationwide General Insurance Company, Titan Indemnity Company, Nationwide Mutual Fire Insurance Company, Nationwide Property & Casualty Insurance Company, Nationwide Assurance Company, Allied Property & Casualty Insurance Company, Depositors Insurance Company, Victoria Select Insurance Company, Victoria Fire & Casualty Insurance Company, Peak Property and Casualty Insurance Corp., Dairyland Insurance Company, a/k/a Sentry Insurance, A Mutual Co., and SIAMCO (collectively, the "**Insurance Companies**"). The Court, having considered the parties' motions and related memoranda of law, the record, and the arguments of counsel, hereby

ORDERS AND ADJUDGES as follows:

Introduction

1. The pleadings, stipulations, and admissible evidence of record demonstrate that there is no genuine issue as to any material fact, and that the MRI Provider and the class are entitled to a partial judgment as a matter of law on their claims for declaratory relief concerning the proper interpretation and application of Section 627.736(5)(a)2.f, 3, and 4, Florida Statutes (2007-2008).[1] Therefore, based on the findings and conclusions set forth below, the MRI Provider's motion for partial summary judgment is hereby **GRANTED**, the Insurance Companies' joint motion for summary judgment is hereby **DENIED**, and the Court hereby provides the declaratory relief set forth herein as a matter of law.

2. These consolidated class action lawsuits involve a dispute over the proper interpretation and application of the statute that governs personal injury protection ("**PIP**") insurance benefits in the State of Florida. The MRI Provider and the class seek declaratory relief, injunctive relief, and damages against the Insurance Companies for allegedly underpaying PIP benefits associated with MRI services provided to PIP insureds in the State of Florida since January 1, 2008.

3. Both of the above-styled lawsuits are brought by the same MRI Provider and raise identical legal issues arising under the same statutory provisions. On May 27, 2009, by stipulation of all parties, the Court consolidated the two cases[2] and entered stipulated orders granting class certification. On July 10, 2009, the Court entered amended stipulated orders granting class certification, an order approving class notices, and a case management conference order setting forth a procedure for the parties to present competing summary judgment motions.

[1] Citations herein to the "2007-2008" versions of the personal injury protection ("**PIP**") statutes refer to the versions in effect since January 1, 2008, as adopted in Chapter 2007-324, Laws of Florida (2007) and Chapter 2008-220, Laws of Florida (2008).

[2] Thereafter, on July 31, 2009, Judge Ralph Stoddard in Division I, entered an order approving the consolidation, and authorizing the consolidated cases to remain assigned to Judge James M. Barton, II in Division C.

4. To date, the parties have filed competing summary judgment motions, stipulated facts, several memoranda of law, numerous exhibits,[3] and proposed orders. The MRI Provider's motion merely seeks partial summary judgment on its claim for declaratory relief, while the Insurance Companies' motion seeks a summary judgment in their favor on all claims. The hearing on these motions was conducted on October 6, 2009, November 23, 2009, and December 22, 2009.

5. It is undisputed that since January 1, 2008, the Insurance Companies have routinely paid for non-emergency, non-hospital magnetic resonance imaging ("**MRI**") services provided to PIP insureds based on Medicare's Hospital Outpatient Prospective Payment System ("**OPPS**") (a.k.a., the "**OPD fee schedule**").[4] The Insurance Companies contend that the OPPS amount is part of the participating physicians schedule of Medicare Part B. *See, e.g.,* Stipulated Facts (filed 9/29/09) at ¶¶ 12, 13, 20, 33d, 45d. The MRI Provider disagrees and contends that PIP insurers are not authorized to rely on the OPPS amount.

6. As explained in the class certification orders, the stipulated facts, and the parties' competing summary judgment motions, the core issue at this juncture is whether the Insurance

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[3] On November 3, 2009, the MRI Provider submitted "Plaintiff's Notice of Filing Evidence in Support of Response to Defendants' Supplemental Memorandum of Law Concerning Competing Motions for Summary Judgment" which included the affidavit of Angela O'Berry. That affidavit indicates that since January 1, 2008, numerous PIP insurance companies (including Allstate, AIG, Progressive, Geico, Liberty Mutual, and others) have consistently paid the MRI Provider's PIP claims in accordance with the MRI Provider's interpretation of Sections 627.736(5)(a)2.f, 3 and/or 4, Florida Statutes (2007-2008). On November 18, 2009, the MRI Provider submitted "Plaintiff's Notice of Filing Supplemental Evidence Concerning Competing Motions for Summary Judgment." Attached to that notice as "Exhibit A" is an Explanation of Benefits form, which purports to show that the Nationwide Defendants recently paid a PIP claim for certain MRI services in accordance with the MRI Provider's interpretation of Sections 627.736(5)(a)2.f, 3 and/or 4, Florida Statutes (2007-2008). By order dated December 2, 2009, this Court granted the Insurance Companies' motion to strike this evidence, over the MRI Provider's objections, and that evidence has not been relied upon by this Court.

[4] Under the federal Medicare statutes and regulations, "OPD" refers to Outpatient Department. *See, Amgen, Inc. v. Smith*, 357 F.3d 103, 111 (D.C. Cir. 2004); *Southwest Mississippi Reg. Medical Center v. Leavitt*, 2009 WL 1011152, *1, n.2 (S.D. Miss. 2009). "OPPS" refers to the Hospital Outpatient Prospective Payment System. *See*, 42 CFR §416.164(4) and §419.1. The Insurance Companies concede that that the OPD fee schedule is the same thing as OPPS. *See*, Defendants' Joint Motion for Summary Judgment at ¶33 ("... the OPPS (aka OPD) amount..."). *See also,* 42 USC §1395*l*(t)(1)(A) and (B) (describing the OPD fee schedule as a "prospective payment system" for "hospital outpatient services").

Companies are authorized by Sections 627.736(5)(a)2.f, 3 and/or 4, Florida Statutes (2007-2008)[5] to cap the amount of PIP benefits paid to MRI providers by applying OPPS and/or any other Medicare restrictions or limitations not specified in those sub-sections of the PIP statute. For the reasons set forth below, this Court answers that question in the negative. [6]

Legislative History

7. In 1971, the Florida Legislature enacted the "Florida Motor Vehicle No-Fault Law" in Sections 627.730 through 627.7405, Florida Statutes. *See,* Ch. 71-252, Laws of Fla. (1971). Since then, Florida has operated under what is commonly known as a "no-fault" system for certain automobile liability claims.

8. Before June 19, 2001, there was no specific statutory methodology for determining the amount of MRI fees paid by PIP insurers. Instead, the pre-2001 version of Section 627.736, Florida Statutes contemplated that MRI services would be paid based upon the same "reasonableness" standard generally applicable to all other types of medical services provided to PIP insureds.

9. As of June 19, 2001, the Legislature enacted Section 627.736(5)(b)5, Florida Statutes (2001), which began imposing a new statutory methodology requiring PIP insurers to pay MRI fees based on a fee schedule published by Medicare. *See*, Ch. 2001-271, Laws of Fla. (2001). The 2001 version of Section 627.736(5)(b)5 states:

> (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
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> . . . . .
>
> (b) ... 5. Effective upon this act becoming a law and before November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed **200 percent of the allowable amount under Medicare Part B for year 2001**, for the area in which the treatment was rendered. Beginning November 1,

[5] The parties do not seek any determinations concerning Section 627.736(1)(a) and/or 5(a)1, Florida Statutes (2007-2008), and those subsections are not at issue in this case. *See,* Stipulated Facts at fn. 5.

[6] While there exists no Florida appellate opinion discussing the issue decided herein, the instant order is consistent with the result reached by the Honorable William P. Levens in *AFO Imaging, Inc. v. Alpha Property &Casualty Ins. Co.,* 16 Fla. L. Weekly 533a (Fla. 13th Jud. Cir. Ct., April 13, 2009). Contra, *Eric Bravo, et al., v. State Farm Fire & Casualty Company,* (Fla. 9th Jud. Cir. Ct., January 14, 2010) (a copy of the Bravo order is attached as Exhibit A).

> 2001, **allowable amounts** that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed **175 percent of the allowable amount under Medicare Part B for year 2001**, for the area in which the treatment was rendered, adjusted annually by an additional amount equal to the medical Consumer Price Index for Florida, except that **allowable amounts** that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services provided in facilities accredited by the American College of Radiology or the Joint Commission on Accreditation of Healthcare Organizations shall not exceed **200 percent of the allowable amount under Medicare Part B for year 2001**, for the area in which the treatment was rendered, adjusted annually by an additional amount equal to the medical Consumer Price Index for Florida. This paragraph does not apply to charges for magnetic resonance imaging services and nerve conduction testing for inpatients and emergency services and care as defined in chapter 395 rendered by facilities licensed under chapter 395. (Emph. added).

Unfortunately, "the allowable amount under Medicare Part B for year 2001" provision was somewhat vague, and that led to litigation between MRI providers and PIP insurers over the meaning of that provision.

10. The case of *Advanced Diagnostic Testing, Inc. v. Allstate Insurance Company*, 2003 WL 23868672 (Fla. 11th Cir. Ct. Oct. 21, 2003), *affirmed*, 888 So.2d 663 (Fla. 3d DCA 2004) ("***Advanced Diagnostic I***") was a dispute between an MRI provider and a PIP insurer over the meaning of the 2001 version of Section 627.736(5)(b)5. The PIP insurer contended that "the allowable amount under Medicare Part B for year 2001" provision referred to the "participating physicians" fee schedule of Medicare Part B, but the MRI provider contended that it referred to the higher "limiting charge" fee schedule of Medicare Part B.[7] The trial court entered a summary judgment finding "as a matter of law that **the phrase 'allowable amount under Medicare Part**

[7] According to federal law, the prices in Medicare's limiting charge fee schedule are 115% of the allowable amounts set forth in the Medicare's **non**-participating physicians fee schedule. *See*, 42 USC §1395w-4(g)(2)(C). The prices in the **non**-participating physicians fee schedule are 95% of the allowable amounts set forth in the Medicare's **participating** physicians fee schedule. *See*, 42 USC §1395w-4(a)(3). Therefore, the limiting charge fee schedule is also 109.25% (i.e., 95% of 115%) of the allowable amounts set forth in the **participating** physicians fee schedule (and the CMS website confirms that this is correct). *See,* Plaintiff's Exhibit A(v) (CMS website – National Physicians Fee Schedule and Relative Value Files); Defendant's Exhibit 2(a)(ii) at p. 2 (CMS "Annual Physicians Fee Schedule Payment Amount" file); Defendant's Exhibit 14(a)(i) at p. 3 (CMS "Annual Physicians Fee Schedule Payment Amount" file).

B' as used in ... Section 627.736(5)(b)5 refers to Medicare's Participating Fee Schedule."

Advanced Diagnostic I, 2003 WL 23868672 at *1 (emph. added).

11. In *Advanced Diagnostic I*, the trial court explained that by seeking the "limiting charge" amount, the MRI provider was essentially attempting to rewrite the PIP statute:

> ... **Application of the limiting charge would be tantamount to re-writing the statutory language of "allowable amount" to mean "maximum allowable amount".** ...Where a statute contains certain provisions and omits others, the statute is ordinarily to be construed as excluding from its operations all those provisions not expressly mentioned. *Special Disability Trust Fund, Department of Labor and Employment Security v. Motor and Compressor Co.*, 446 So.2d 224, 226-227 (Fla. 1st DCA 1984). The legislature was capable of drafting the phrase to read "maximum allowable amount." More specifically, Section 5(b)2, which addresses diagnostic procedures other than MRIs, uses the phrase "maximum reimbursement allowance" ....
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> .....
>
> ... The Legislature specifically employed the definite article "the allowable amount" rather than "a" or "any" allowable amount. **The most sensible reading of the phrase "the allowable amount" suggests that the legislature intended for a specific Medicare schedule to be incorporated into the PIP statute, rather than either, any, or all of the schedules.** *See, State v. Mitchell*, 719 So.2d 1245 (Fla. 1st DCA 1998) (distinguishing between use of articles); *State v. Grappin*, 427 So.2d 760 (Fla. 2d DCA 1983 (same). **Using this interpretation of the language, the phrase "the allowable amount" can only mean that the participating rate would apply to this Plaintiff.**

Advanced Diagnostic I, 2003 WL 23868672 at *8-*9 (emph. added). As part of its decision, the trial court certified the following question to the Third DCA as one of great public importance:

> **Does the phrase "allowable amount under Medicare Part B" as used in Fla. Stat. Section 627.736(5)(b)5 refer only to Medicare's "participating fee schedule"** or does the phrase "allowable amount" instead refer to Medicare's "limiting charge" amount?

Advanced Diagnostic I, 2003 WL 23868672 at *11 (emph. added).

12. Thereafter, in *Advance Diagnostic Testing v. Allstate Insurance Co.*, 888 So.2d 663 (Fla. 3d DCA 2004) ("***Advanced Diagnostic II***"), the Third DCA agreed with the trial court's analysis and held:

> ... [W]e answer the certified question and hold that **the term "the allowable amount under Medicare Part B," as used in section 627.736(5)(b)5, refers to**

> **the "participating physician fee schedule of Medicare Part B,"** and affirm the final summary judgment.

Advance Diagnostic II, 888 So.2d at 664 (emph. added). *See also, Millennium Diagnostic Imaging Ctr., Inc. v. Sec. Nat'l Ins. Co.*, 882 So.2d 1027 (Fla. 3d DCA 2004) (legislative history and language of 2003 amendment to §627.736(5)(b)5, established that "the participating fee schedule was the proper fee schedule under the [2001] statute").

13. Other published cases likewise used the participating physicians schedule of Medicare Part B when determining the allowable amount payable by PIP insurers under former Section 627.736(5)(b)5. *See, e.g., MRI Associates of St. Pete v. Progressive Express Insurance Co.,* 15 Fla. L. Weekly Supp. 182a (Fla. 13th Cir. Ct. 2007) (identifying $517.50 as the "2001 Medicare Part B Fee Schedule" amount for CPT code 72141); *Altamonte Springs Imaging, Inc. v. Progressive Express Insurance Co.,* 15 Fla. L. Weekly Supp. 265c (Fla. 9th Cir. Ct. 2007) (identifying $517.50 as the "Amount allowed for CPT code 72141 under 2001 Medicare Part B physician fee schedule"). Absent a statutory definition, courts can resort to definitions of the same term found in case law. *See, e.g., Rollins v. Pizzarelli*, 761 So.2d 294, 298 (Fla. 2000).

14. Meanwhile, in 2003, the Legislature amended the PIP statute to clarify "the allowable amount under Medicare Part B" provision. *See*, Ch. 2003-411, Laws of Fla. (2003). Consistent with the conclusions reached in the *Advanced Diagnostic* cases and similar decisions, the 2003 amendment clarified that "the allowable amount under the participating physician fee schedule of Medicare Part B for 2001" was the proper schedule to be used:

> (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
>
> (b) ... 5. Effective upon this act becoming a law and before November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 200 percent of the allowable amount under Medicare Part B for year 2001, for the area in which the treatment was rendered. Beginning November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 175

> percent of **the allowable amount under <u>the participating physician fee schedule of</u> Medicare Part B** for year 2001, for the area in which the treatment was rendered, adjusted annually ... except that allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services provided in facilities accredited ... shall not exceed 200 percent of **the allowable amount under <u>the participating physician fee schedule of</u> Medicare Part B** for year 2001, for the area in which the treatment was rendered, adjusted annually ....

See, Ch. 2003-411, §8, Laws of Fla. (2003) (bold added; underline and strike-thru original). The Legislature is presumed to know the pre-existing law when it adopts a statute. *See, e.g., Holmes County School Bd. v. Duffell*, 651 So.2d 1176 (Fla. 1995). As demonstrated above, in its 2003 clarifying amendment of the PIP statute, the Florida Legislature adopted the same result as the courts reached in the *Advanced Diagnostic* cases and similar decisions.

15. Effective on October 1, 2007, the Florida Motor Vehicle No-Fault Law was automatically repealed by a "sunset" provision. *See,* Ch. 2003-411, §19, Laws of Fla. (2003). As a result, the State of Florida went without a PIP statute during the last three months of 2007.

16. After the PIP statute's sunset repeal, the Legislature enacted a new set of statutes as the "Florida Motor Vehicle No-Fault Law" which became effective as of January 1, 2008. *See,* Ch. 2007-324, §8, Laws of Fla. (2007). As of that date, the new version of Section 627.736(5) stated in pertinent part:

> (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
>
> (a) ... 2. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:
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> a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.
>
> b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.
>
> c. For emergency services and care as defined by s.395.002(10) provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. **For all other medical services, supplies, and care, 200 percent of the applicable Medicare Part B fee schedule.** However, if such services, supplies, or care are not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care are provided. Services, supplies, or care that are not reimbursable under Medicare or workers' compensation are not required to be reimbursed by the insurer.

3. For purposes of subparagraph 2., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect at the time the services, supplies, or care were rendered and for the area in which such services were rendered, except that **it may not be less than the applicable 2007 Medicare Part B fee schedule for medical services, supplies, and care subject to Medicare Part B**.

4. **Subparagraph 2. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare** or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, **regardless of whether such provider would be entitled to reimbursement under Medicare** due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

Ch. 2007-324, §20, Laws of Fla. (emph. added). It is undisputed that the MRI services at issue in this case were provided in a non-emergency, non-hospital setting, and therefore, they fall within the type of "other medical services, supplies, and care" governed by Section 627.736(5)(a)2.f. *See*, Stipulated Facts at ¶15.

17. Unfortunately, the above-quoted version of Section 627.736(5)(a) adopted in late 2007 did not specify or define "the applicable Medicare Part B fee schedule" or "the applicable

2007 Medicare Part B fee schedule" referenced in subsections (5)(a)2.f and (5)(a)3.[8] As previously explained in ¶¶ 9-14 above, a nearly identical situation arose in 2001, when the original version of Section 627.736(5)(b)5 did not identify which particular fee schedule "under Medicare Part B for year 2001" that would apply to MRI charges. *See,* Ch. 2001-271, Laws of Fla. (2001). As a result, the Legislature subsequently amended Section 627.736(5)(b)5 in 2003, to clarify that the "participating physician fee schedule" of Medicare Part B for 2001 was the proper schedule to be used. *See,* Ch. 2003-411, §8, Laws of Fla. (2003).

18. As with the 2003 amendment to Section 627.736(5)(b)5, the Legislature likewise amended Section 627.736(5)(a)2.f and 3 on June 23, 2008 to clarify that "the applicable Medicare Part B fee schedule" refers only to the "participating physicians schedule" of Medicare Part B (i.e., the exact same fee schedule that was previously identified in the 2003 clarifying legislation, and in the *Advanced Diagnostic* decisions). *See,* Ch. 2008-220, §22, Laws of Fla. (2008). As clarified, Section 627.736(5)(a)2.f and 3 now states:

> (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
>
> [(a)2.]f. For all other medical services, supplies, and care, 200 percent of the allowable amount under the participating physicians schedule of ~~applicable~~ Medicare Part B ~~fee schedule~~. However, if such services, supplies, or care are not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care are provided. Services, supplies, or care that are not reimbursable under Medicare or workers' compensation are not required to be reimbursed by the insurer.
>
> 3. For purposes of subparagraph 2., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect at the time the services, supplies, or care were rendered and for the area in which such services were rendered, except that it may not be less than the allowable amount

[8] The federal statutes governing Medicare Part B establish several different fee schedules, including the participating physicians schedule, the non-participating physicians schedule, the limiting charge schedule, and the OPD fee schedule. *See,* 42 USC §1395w-4 and §1395*l*(t). Thus, depending on the nature of the services rendered and the type of health care provider rendering those services, "the applicable Medicare Part B fee schedule" provisions of sub-sections (5)(a)2.f and (5)(a)3 might potentially refer to any one of several different fee schedules.

> under the participating physicians schedule ~~applicable 2007~~ [of[9]] Medicare Part B for 2007 ~~fee schedule~~ for medical services, supplies, and care subject to Medicare Part B.

Ch. 2008-220, §22, Laws of Fla. (2008) (underline and strike-through in original). Thus, the very broad "applicable Medicare Part B fee schedule" provision was replaced with the very specific "allowable amount under the participating physicians schedule of Medicare Part B" provision.

19. The legislative analysis associated with the 2008 legislation states, "under current law, insurers are allowed to limit reimbursement for PIP benefits to 80 percent of 200 percent of the Medicare Part B fee schedule for specified medical service. The amendment **clarifies** that PIP reimbursement for medical services would be based on 200 percent of the allowable amount under the **'participating physicians' schedule of Medicare Part B for 2007**." *See,* Florida Senate's House Message Summary (May 1, 2008), at p. 2 (emph. added).

20. When the Legislature merely intends to clarify what was doubtful and safeguard against misapprehension as to existing law, then an amendment to a statute should be interpreted to clarify the pre-existing law and not enact a subsequent change. *State ex. Rel. Szabo Food Serv. Inc. of N.C. v. Dickinson,* 286 So. 2d 529, 531 (Fla. 1974); *U.S. Fire Ins. Co v. Roberts*, 541 So. 2d 1297 (1st DCA 1989); *City of New Smyrna Beach v. Bd. of Trustees of Internal Imp. Trust Fund*, 543 So.2d 824 (Fla. 5th DCA 1989). Thus, the 2008 clarifying legislation did not enact a substantive change to the 2007 version of Section 627.736(5)(a) and both versions of the statute must be interpreted to mean the same thing.[10] *See, e.g., Millennium Diagnostic Imaging Center, Inc. v. Security National Ins. Co.,* 882 So.2d 1027 (Fla.3d DCA 2004); *Clearview Imaging, L.L.C. v. State Farm Mut. Auto. Ins. Co.*, 932 So.2d 423 (Fla. 2d DCA 2006); *Ivey v.*

[9] As an apparent scrivener's error, the word "of" was omitted from the 2008 legislation. This word was subsequently inserted in a reviser's bill. *See,* Ch. 2009-21, §86, Laws of Fla. (2009).

[10] All parties in this case agree that the 2008 clarifying legislation did not enact a substantive change to the 2007 version of Section 627.736(5)(a) and both versions of the statute must be interpreted to mean the same thing. *See, e.g.,* Amended Stipulated Order Granting Joint Motion for Class Certification (July 10, 2009) at ¶7.

Chicago Ins. Co., 410 So.2d 494, 497 (Fla.1982). Thus, it is clear that PIP insurers cannot rely upon just any "applicable Medicare Part B fee schedule" (as broadly stated in the original version of the statute). Rather, as narrowly clarified by the Legislature, Section 627.736(5)(a)2.f and 3 require PIP insurers to pay for MRI services based on "the allowable amount under the participating physicians schedule of Medicare Part B," and not less than "the allowable amount under the participating physicians schedule of Medicare Part B for 2007."

21. Additionally, Section 627.736(5)(a)4, Florida Statutes (2007-2008) further limits a PIP insurer's ability to rely on the Medicare laws for any purpose other than using "the allowable amount under the participating physicians schedule of Medicare Part B" as a baseline reimbursement level. As previously quoted herein, Section 627.736(5)(a)4 states that "Subparagraph [(5)(a)]2. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph [(5)(a)]2. **must** reimburse a provider who lawfully provided care or treatment under the scope of his or her license, **regardless of whether such provider would be entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.**" (Emph. added).

22. At this point, it is important to read Section 627.736(5)(a)2.f and 4 in *para materia.*[11] The applicable parts of Section 627.736(5)(a)2.f and 4 are as follows:

> 2. .... f. For all other medical services, supplies, and care, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. However, **if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation**, as

[11] *See, e.g., Abbott Laboratories v. Mylan Pharmaceuticals, Inc.*, 15 So.3d 642, 657 (Fla.1st DCA 2009) (it is axiomatic that statutes must be read in *para materia* with other related statutes and other related portions of the same statute). Moreover, whenever possible, courts must give effect to all statutory provisions and construe related statutory provisions in harmony with one another. *See, e.g., Forsythe v. Longboat Key Beach Erosion Control Dist.*, 604 So.2d 452, 455 (Fla.1992).

determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. **Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer**.

. . . . . .

4. Subparagraph 2. does not allow the insurer to apply any **limitation on the number of treatments** or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 2. **must** reimburse a provider who lawfully provided care or treatment under the scope of his or her license, **regardless of whether such provider would be entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.**

(Emph. added). Thus, Subsection (5)(a)2.f addresses situations when services, supplies, or care are "**not reimbursable** under Medicare Part B ... [or] workers' compensation rates." In that event, the PIP insurer "is not required" to reimburse the health care provider. In contrast, Subsection (5)(a)4 addresses situations when Medicare merely imposes "**restrictions or limitations**" on reimbursement. In that event, the PIP insurer "must reimburse" a health care provider who lawfully provided the services "regardless" of those Medicare restrictions or limitations.

23. Thus, under Section 627.735(5)(a)2.f, 3, and 4, Florida Statutes (2007-2008), "the allowable amount under the participating physicians schedule of Medicare Part B for 2007" sets the lowest amount upon which a PIP insurer's payments for MRI services may be based. In other words, the 2007 Medicare Part B participating physicians fee schedule must be used whenever the Medicare fee schedule in effect at the time the MRI services are rendered is "less than the allowable amount under the participating physicians schedule Medicare Part B for 2007...." First, under Section 627.736(5)(a)2.f, the "participating physicians" schedule of Medicare Part B is the proper fee schedule. Second, under Section 627.736(5)(a)2.f and 3, 80% of 200% of the participating physicians schedule Medicare Part B for 2007 is the absolute minimum reimbursement that a PIP insurer may pay an MRI provider. Third, under Section

627.735(5)(a)4, a PIP insurer must pay "regardless" of any other Medicare restrictions or limitations on the number of treatments, or the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

24. With this legislative history in place, it is now necessary to interpret what the Florida Legislature means by "the allowable amount under the participating physicians schedule of Medicare Part B" provisions of Section 627.735(5)(a)2.f and 3. The answer to that question requires an analysis of the federal laws governing Medicare.

The Medicare Program

25. The Medicare program was enacted into federal law in 1965, as part of the Social Security Act. Social Security is governed by 42 USC Chapter 7, and Subchapter XVIII of Chapter 7 pertains to the Medicare program. *See,* 42 USC §§ 1395-1395ggg. The Medicare program is divided into four parts. Medicare "Part A" is addressed in 42 USC §§ 1395c through 1395i-5. Medicare "Part B" is addressed in 42 USC §§ 1395j through 1395w-4. Medicare "Part C" is addressed in 42 USC §§ 1395w-21 through 1395w-28. Medicare "Part D" is addressed in 42 USC §§ 1395x through 1395ggg.

26. The Medicare program has traditionally been broken down into broad categories. "Part A" of the Medicare program covers inpatient care provided by hospitals, skilled nursing facilities, and home health agencies (*see*, 42 USC §§ 1395c through 1395i-5), while "Part B" of the Medicare program covers outpatient and physician services (*see*, 42 USC §§ 1395j through 1395w-4). The Medicare statutes, regulations, and policies use a wide variety of payment methods, which depend on such factors as the type of service involved, the type of health care provider, and the site at which the service is provided, among many other factors.

27. The Medicare program is administered by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("**CMS**"). Moreover, in every state,

CMS enters into "a contract" with private companies, which act as third party administrators or "carriers" who "determine and make Medicare **payments** for Part B benefits payable on a charge basis and to perform other related functions." *See,* 42 CFR §400.202 (emph. added). CMS's third party administrator or "carrier" in Florida is a private "for-profit" Florida corporation known as First Coast Service Options, Inc. *See*, Plaintiff's Exhs. A(y) and A(b) at ¶20. Notably, the CMS carrier's function is to determine and actually make Medicare "payments" to Medicare health care providers on behalf of the federal government. Further, it is clear that CMS and its carrier in Florida (First Coast Service Options, Inc.) have no duties or functions under the Florida PIP statute. *Id.*

28. CMS generates the participating physicians schedule of Medicare Part B pursuant to 42 USC §1395w-4, which is titled "Payment for physicians' services." Section 1395w-4 is 34 pages long, very complex, and includes numerous formulas, transition schedules, special rules, incentives, exceptions, and adjustment mechanisms, among other provisions. For purposes of understanding what the Florida Legislature means by "the allowable amount under the participating physicians schedule of Medicare Part B" provisions of Section 627.735(5)(a)2.f and 3, the key provisions of Section 1395w-4 are as follows:

§ 1395w–4. Payment for physicians' services

(a) Payment based on fee schedule

(1) In general

> Effective for all physicians' services (as defined in subsection (j)(3) of this section) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1395m (b) of this title, payment under this part shall instead be based on the lesser of—
>
> (A) the actual charge for the service, or
>
> (B) subject to the succeeding provisions **of this subsection**

[i.e., subsection (a)], **the amount determined under the fee schedule established under subsection (b) of this section** for services furnished during that year (in this subsection referred to as the "fee schedule amount").

. . . . .

(b) Establishment of fee schedules

(1) In general

Before November 1 of the preceding year, for each year beginning with 1998, the Secretary shall establish, by regulation, **fee schedules** that establish payment amounts for all physicians' services furnished in all fee schedule areas (as defined in subsection (j)(2) of this section) for the year. **Except as provided in paragraph (2)** [of §1395w-4(b) which pertains to certain radiology and anesthesia services], each such payment amount for a service **shall be equal to the product of**—

(A) the **relative value for the service** (as determined in subsection (c)(2) of this section),

(B) the **conversion factor** (established under subsection (d) of this section) for the year, and

(C) the **geographic adjustment factor** (established under subsection (e)(2) of this section) for the service for the fee schedule area.

. . . . .

(4) Special rule for imaging services

(A) In general

In the case of imaging services described in subparagraph (B) furnished **on or after January 1, 2007, if**—

(i) **the technical component** (including the technical component portion of a global fee) **of the service established for a year under the fee schedule described in paragraph (1)** without application of the geographic adjustment factor described in paragraph (1)(C), **exceeds**

(ii) **the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services** under paragraph (3)(D) of section 1395*l*(t) of this title for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such section,

the Secretary shall substitute the amount described in clause (ii), adjusted by the geographic adjustment factor described in paragraph (1)(C), **for the fee schedule amount** for such technical

component for such year.

(B) Imaging services described
For purposes of subparagraph (A), imaging services described in this subparagraph are imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), **magnetic resonance imaging**, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography.

. . . . .

(Emph. added). While somewhat complex, the various provisions of 42 USC §1395w-4 demonstrate that the participating physicians fee schedule (i.e., the fee schedule described in §1395w-4(b)(1)) is created by using a **statutory formula** (in §1395w-4(b)(1)(A)-(C)) that generates an allowed amount for various particular types of health care services.

29. With this backdrop in place, the Court now proceeds to analyze the parties' arguments in this case.

With respect to "imaging services," is the OPPS amount indicated in the OPD fee schedule, the same thing as "the allowable amount under the participating physicians schedule of Medicare Part B" for purposes of the Florida PIP statute?

30. In this case, the Insurance Companies rely on 42 USC §1395w-4(b)**(4)** (i.e., the "Special rule for imaging services")[12] for the proposition that "the allowable amount under the participating physicians schedule of Medicare Part B" is actually the OPPS or "OPD fee schedule amount" with respect to imaging services rendered to a PIP insured. For several reasons, this Court disagrees.

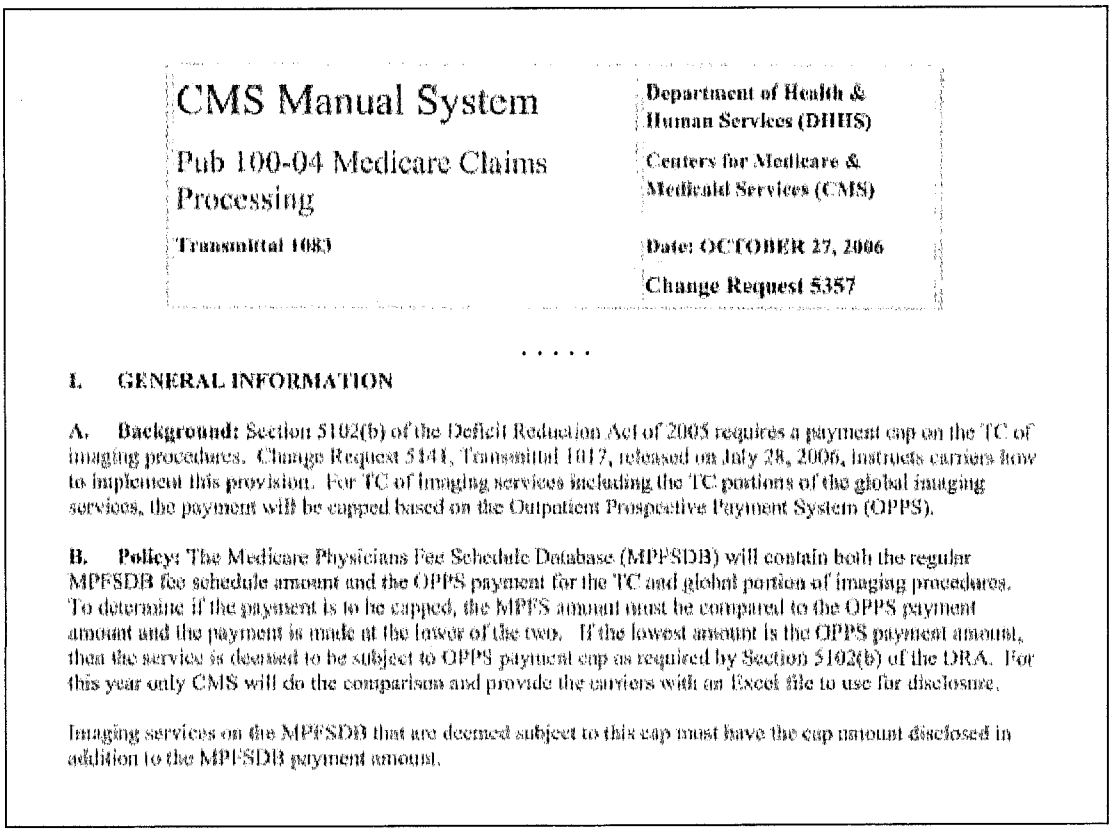
31. Regardless of the numerous complex special rules and other provisions throughout 42 USC §1395w-4, subsection (b)(1) of that statute is crystal clear. It expressly

[12] In 2005, the U.S. Congress passed the federal "Deficit Reduction Act of 2005." *See*, Pub. L. 109-171. Among other things, that Act amended 42 USC §1395w-4 to insert subsection (b)(4) as a new payment limitation procedure, known as the "Special rule for imaging services" to help the federal government reduce the federal deficit by reducing the amount of money that the federal government will pay for imaging services provided by certain types of health care provider to Medicare recipients. As stated in §1395w-4(b)(4)(A)(i), this "Special rule" applies to those health care providers who render "the technical component" of imaging services, including MRIs.

states, "***Except as provided in paragraph (2)***" of §1395w-4(b), the allowable amounts under the participating fee schedule are calculated using the statutory formula expressly set forth in §1395w-4(b)(1)(A)-(C). In other words, the participating physicians schedule is the fee schedule generated solely and exclusively by §1395w-4(b)(1) and (2), without regard to any other subsections, paragraphs, or subparagraphs of §1395w-4. The "Special rule for imaging services" relied upon by the Insurance Companies is found in paragraph (4) of §1395w-4(b). Consequently, the Insurance Companies essentially request this Court to rewrite 42 USC §1395w-4(b)(1) to state that the allowable amounts under the participating fee schedule are calculated using the statutory formula expressly set forth in §1395w-4(b)(1)(A)-(C), "Except as provided in paragraph**s** (2) **and (4)**." This Court is not permitted to add words to §1395w-4(b)(1) that were not placed there by the United States Congress. *See, e.g., Hayes v. State*, 750 So. 2d 1, 4 (Fla. 1999); *Bay Holdings, Inc. v. 2000 Island Boulevard Condo. Ass'n*, 895 So. 2d 1197, 1197 (Fla. 3d DCA 2005). *See also, Holly v. Auld*, 450 So. 2d 217, 219 (Fla. 1984) (courts are without power to construe an unambiguous statute in a way which would extend, modify, or limit its express terms); *Ervin v. Collins*, 85 So. 2d 852, 855 (Fla. 1956) (court is not permitted to revise an unambiguous statute by "engrafting ... [its] views as to how it should have been written"). Because the "Special rule for imaging services" is found in §1395w-4(b)(4), and is not found in §1395w-4(b)(1) or (2), that special rule does not generate the Medicare Part B participating physicians schedule.

32. The differences between the participating physicians schedule and the OPD fee schedule are explained in various official CMS publications. As the federal agency charged with implementing the Medicare system, CMS's interpretations of the federal Medicare statutes and regulations are entitled to substantial deference. *See, e.g., Delta Health Group, Inc. v. U.S. Dept. of Health and Human Services*, 459 F.Supp.2d 1207, 1224 (N.D. Fla. 2006).

33. Official CMS publications confirm that instead of generating the Medicare Part B participating physicians fee schedule, the "Special rule for imaging services" found in 42 USC §1395w-4(b)(4) is merely a limitation or restriction (or cap) on the amount of money paid for imaging services provided to Medicare recipients, based on the "OPD fee schedule" established for OPPS. For example, CMS issued an official guidance publication in 2006 explaining that under the federal Deficit Reduction Act of 2005, the OPD fee schedule cap amount is still separate and distinct from the participating physicians fee schedule amount, and instructed both amounts to be disclosed. As stated in *CMS Manual System Pub 100-04*:



CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 1083

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: OCTOBER 27, 2006

Change Request 5357

. . . . .

I. GENERAL INFORMATION

A. **Background:** Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the TC of imaging procedures. Change Request 5141, Transmittal 1017, released on July 28, 2006, instructs carriers how to implement this provision. For TC of imaging services including the TC portions of the global imaging services, the payment will be capped based on the Outpatient Prospective Payment System (OPPS).

B. **Policy:** The Medicare Physicians Fee Schedule Database (MPFSDB) will contain both the regular MPFSDB fee schedule amount and the OPPS payment for the TC and global portion of imaging procedures. To determine if the payment is to be capped, the MPFS amount must be compared to the OPPS payment amount and the payment is made at the lower of the two. If the lowest amount is the OPPS payment amount, then the service is deemed to be subject to OPPS payment cap as required by Section 5102(b) of the DRA. For this year only CMS will do the comparison and provide the carriers with an Excel file to use for disclosure.

Imaging services on the MPFSDB that are deemed subject to this cap must have the cap amount disclosed in addition to the MPFSDB payment amount.

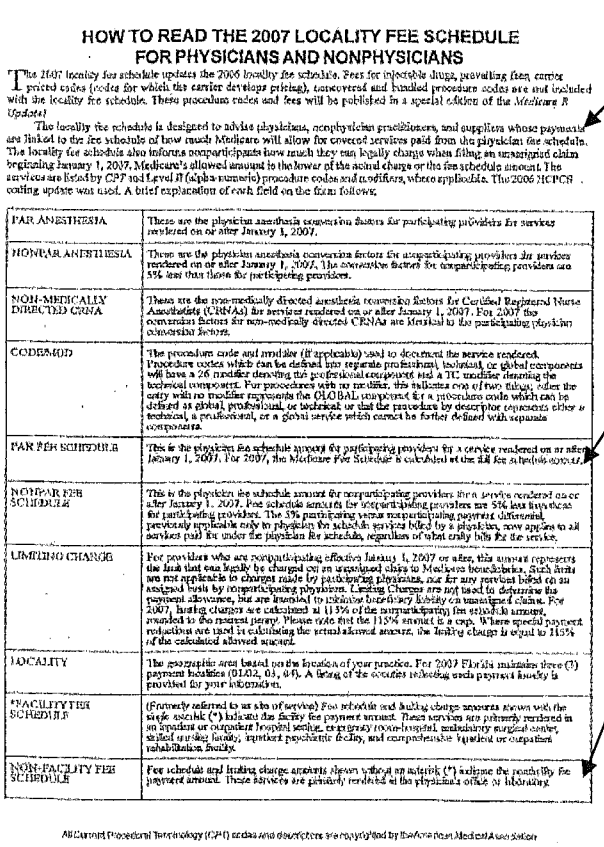
See, Plaintiff's Exhibit A(t). According to the above-quoted official CMS "Policy" statement, there is an OPPS "cap amount" generated under the "Special rule for imaging services," but there is still a separate and distinct "MPFSDB payment amount." This policy is consistent with Congress's express instructions that the Medicare Part B participating physicians schedule is

calculated using the statutory formula in §1395w-4(b)(1)(A)-(C), "[e]xcept as provided in paragraph (2)" of §1395w-4(b). Because the "Special rule for imaging services" is found in paragraph (4), it does not control the allowable amounts under the participating physicians schedule created by §1395w-4(b)(1) and (2), and therefore, CMS directed its carriers to disclose both amounts.

34. Other CMS publications likewise confirm the distinct and separate nature of the participating physicians schedule and the OPD fee schedule. From 2000 through 2007, CMS published hard copy booklets known as the "Medicare Part B Physician and Non-Physician Practitioner Fee Schedule," and complete copies of those booklets are filed as exhibits. *See,* Plaintiff's Exhs. A(f), A(g), A(h), A(i), A(j), A(k), A(l), and A(m). Each booklet provided allowable amounts for the participating fee schedule, the non-participating fee schedule, and the limiting charge fee schedule. *Id.*

35. At the beginning of each "Medicare Part B Physician and Non-Physician Practitioner Fee Schedule" booklet, CMS includes an instruction page titled, "HOW TO READ THE [YEAR] LOCALITY FEE SCHEDULE FOR PHYSICIANS AND NONPHYSICIANS." *See, e.g.,* Plaintiff's Exh. A(f) at 6th unnumbered page (for 2007 booklet). That instruction page defines certain terms the same way, each and every year. For instance, the term "allowed amount" is always defined at the top of the instruction page for each year, as follows: **"Medicare's allowed amount is the lower of the actual charge or the fee schedule amount"**. The CMS instruction page always defines the "PAR FEE SCHEDULE" as "the **physician fee schedule** amount for **participating** providers for a service rendered on or after January 1, [year]. For [year], the Medicare Fee Schedule is calculated **at the full fee schedule amount.**" Each year's CMS instruction page also defines the term, "NON-FACILITY FEE SCHEDULE" as **"Fee schedule and limiting charge amounts shown without an asterisk (*) indicate the non-**

facility fee payment amount. These services are primarily rendered in the physician's office or laboratory." *See*, Plaintiff's Exhs. A(f), A(g), A(h), A(i), A(j), A(k), A(l), and A(m) at each year's CMS instruction pages. Provided below for illustration, is a copy of the CMS instruction page for 2007, with the terms "allowed amount," "Par[ticipating] Fee Schedule," and "Non-Facility Fee Schedule" defined therein, and enlarged on the right-hand side:



HOW TO READ THE 2007 LOCALITY FEE SCHEDULE FOR PHYSICIANS AND NONPHYSICIANS

The 2007 locality fee schedule updates the 2006 locality fee schedule. Fees for injectable drugs, prevailing fixed carrier priced codes (codes for which the carrier develops pricing), unlisted and bundled procedure codes are not included with the locality fee schedule. These procedure codes and fees will be published in a special edition of the *Medicare B Update*.

The locality fee schedule is designed to advise physicians, nonphysician practitioners, and suppliers whose payments are linked to the fee schedule of how much Medicare will allow for covered services paid from the physician fee schedule. The locality fee schedule also informs nonparticipants how much they can legally charge when filing an unassigned claim beginning January 1, 2007. Medicare's allowed amount is the lower of the actual charge or the fee schedule amount. The services are listed by CPT and Level II (alpha-numeric) procedure codes and modifiers, where applicable. The 2006 HCPCS coding update was used. A brief explanation of each field on the form follows:

PAR ANESTHESIA	These are the physician anesthesia conversion factors for participating providers for services rendered on or after January 1, 2007.
NONPAR ANESTHESIA	These are the physician anesthesia conversion factors for nonparticipating providers for services rendered on or after January 1, 2007. The conversion factors for nonparticipating providers are 5% less than those for participating providers.
NON-MEDICALLY DIRECTED CRNA	These are the non-medically directed anesthesia conversion factors for Certified Registered Nurse Anesthetists (CRNAs) for services rendered on or after January 1, 2007. For 2007 the conversion factors for non-medically directed CRNAs are identical to the participating physician conversion factors.
CODE/MOD	The procedure code and modifier (if applicable) used to document the service rendered. Procedure codes which can be defined into separate professional, technical, or global components will have a 26 modifier denoting the professional component and a TC modifier denoting the technical component. For procedures with no modifier, the tabulation can of two things; either the entry with no modifier represents the GLOBAL component for a procedure code which can be defined as global, professional, or technical or that the procedure by descriptor represents either a technical, a professional, or a global service which cannot be further defined with separate components.
PAR FEE SCHEDULE	This is the physician fee schedule amount for participating providers for a service rendered on or after January 1, 2007. For 2007, the Medicare Fee Schedule is calculated at the full fee schedule amount.
NONPAR FEE SCHEDULE	This is the physician fee schedule amount for nonparticipating providers for a service rendered on or after January 1, 2007. Fee schedule amounts for nonparticipating providers are 5% less than those for participating providers. The 5% participating versus nonparticipating payment differential previously applicable only to physician fee schedule services billed by a physician, now applies to all services paid for under the physician fee schedule, regardless of what entity bills for the service.
LIMITING CHARGE	For providers who are nonparticipating effective January 1, 2007 or after, this amount represents the limit that can legally be charged on an unassigned claim to Medicare beneficiaries. Such limits are not applicable to charges made by participating physicians, nor for any services billed on an assigned basis by nonparticipating physicians. Limiting Charges are not used to determine the payment allowance, but are intended to minimize beneficiary liability on unassigned claims. For 2007, limiting charges are calculated at 115% of the nonparticipating fee schedule amount, rounded to the nearest penny. Please note that the 115% amount is a cap. Where special payment reductions are used in calculating the actual allowed amount, the limiting charge is equal to 115% of the calculated allowed amount.
LOCALITY	The geographic area based on the location of your practice. For 2007 Florida maintains three (3) payment localities (01,02, 03, 04). A listing of the counties reflecting each payment locality is provided for your information.
*FACILITY FEE SCHEDULE	(Formerly referred to as site of service) Fee schedule and limiting charge amounts shown with the single asterisk (*) indicate the facility fee payment amount. These services are primarily rendered in an inpatient or outpatient hospital setting, emergency room-hospital, ambulatory surgical center, skilled nursing facility, inpatient psychiatric facility, and comprehensive inpatient or outpatient rehabilitation facility.
NON-FACILITY FEE SCHEDULE	Fee schedule and limiting charge amounts shown without an asterisk (*) indicate the nonfacility fee payment amount. These services are primarily rendered in the physician's office or laboratory.

All Current Procedural Terminology (CPT) codes and descriptors are copyrighted by the American Medical Association

"The locality fee schedule is designed to advise physicians, nonphysician practitioners, and suppliers whose payments are **linked to** the fee schedule of how much Medicare **will allow** for covered services paid from the physician fee schedule. … Medicare's **allowed amount** is the lower of the actual charge or **the fee schedule amount**."

"PAR FEE SCHEDULE … **This is the physician fee schedule amount for participating** providers for a service rendered on or after January 1, [year]. For [year], the Medicare Fee Schedule is calculated **at the full fee schedule amount**."

"NON-FACILITY FEE SCHEDULE … Fee schedule and limiting charge **amounts shown without an asterisk (*) indicate the non-facility fee payment amount**. These services are primarily rendered in the physician's office or laboratory."

See, Plaintiff's Exh. A(f) at 6th unnumbered page (emph. added).

36. Thus, contrary to the Insurance Companies' arguments, the CMS instruction page explains that the "allowed amount" is the "fee schedule amount." Further, the CMS instruction page always defines the "PAR[ticipating] FEE SCHEDULE" as "the physician fee schedule amount for participating providers … calculated at the **full** fee schedule amount." (Emph. added). In other words, according to CMS, the "allowed amount" under the participating physicians schedule (or "PAR FEE SCHEDULE") is the "**full fee schedule amount**," rather than an amount that is subject to any limitations, restrictions or caps. Clearly, the "Special rule for

imaging services" of 42 USC §1395w-4(b)(4) does not generate the "full" fee schedule amount. Rather, that special rule instructs the CMS Secretary to substitute the OPD fee schedule amount whenever it is lower than the participating physicians schedule allowed amount.

37. After establishing that the "PAR[ticipating] FEE SCHEDULE" is "the physician fee schedule amount for participating providers ... calculated at the **full** fee schedule amount," the CMS booklets also confirm that the participating physicians amount (i.e., full fee schedule amount) is also the exact same as the "Non-Facility" price for services rendered outside of an emergency room or hospital. As quoted above, each CMS instruction page defines the term, "NON-FACILITY FEE SCHEDULE" as "Fee schedule... amounts shown without an asterisk (*) indicate the non-facility fee payment amount..." Thus, when medical services are rendered to a patient in a "Non-Facility" setting (i.e., outside of an emergency room or hospital), those services are not marked with an asterisk on the Medicare Physician Fee Schedule, and are considered "Non-Facility" services, which maintain the same allowable amounts as the participating physicians fee schedule. Therefore, an allowable amount for a certain procedure code listed under the "PAR[ticipating] FEE SCHEDULE" is the exact same as the "NON-FACILITY" price. Indeed, the Insurance Companies' own evidence filed in this matter (Defendant's Exhibit 14(a)(i)), titled, "Annual Physician Fee Schedule Payment Amount File," specifically defines "Non-Facility Fee Schedule" and explains that "the law sets the payment amount for nonparticipating physicians at 95 percent of **the payment amount for participating physicians (i.e., the full fee schedule amount.)**" (Emph. added).

38. After 2007, Medicare went "paperless" and CMS discontinued its distribution of the "Medicare Part B Physician and Non-Physician Practitioner Fee Schedule" booklets. Thus, for 2008 and 2009, the full (i.e., participating) Medicare Physicians Fee Schedule can now only be accessed and printed from the official CMS Physician Fee Schedule Lookup website

(www.cms.hhs.gov/PFSlookup/02_PFSSearch.asp#TopOfPage). *See,* Plaintiff's Composite Exh. 1, Tab 6, at p. 36 and 40.

39. During the summary judgment hearing, the Insurance Companies submitted 2008 and 2009 price documents generated by First Coast Services Options, Inc. (a private for-profit Florida corporation). These booklets have a similar instruction page which include all of the same definitions found in the CMS booklets for 2000-2007, but also include an additional definition for "C-OPPS-CAP," which explains that every MRI procedure code listed within those booklets are "**capped**" amounts, instead of the "full" fee schedule amounts:

How to Read the 2008 Locality Fee Schedule for Physicians and Nonphysicians
The 2008 locality fee schedule updates the 2007 locality fee schedule. Fees for injectable drugs, prevailing fees, carrier priced codes (codes for which the carrier develops pricing), noncovered and bundled procedure codes are not included with the locality fee schedule. These procedure codes and fees will be published in a special edition of the *Medicare B Update!*
The locality fee schedule is designed to advise physicians, nonphysician practitioners, and suppliers whose payments are linked to the fee schedule of how much Medicare will allow for covered services paid from the physician fee schedule. The locality fee schedule also informs nonparticipants how much they can legally charge when filing an unassigned claim beginning January 1, 2008. Medicare's allowed amount is the lower of the actual charge or the fee schedule amount. The services are listed by *CPT* and Level II (alpha-numeric) procedure codes and modifiers, where applicable. The 2008 HCPCS coding update was used. A brief explanation of each field on the form follows:

....

C – OPPS CAP	Fee schedule and limiting charge amounts shown with "C" indicates the technical component payment amount is capped at the OPPS amount.

See, Plaintiff's Composite Exhibit 1, Tab 6, at p. 34 and 38. The above-quoted First Coast Services Options, Inc. definition actually defeats the Insurance Companies' argument. Those documents define the "C-OPPS CAP" as "Fee schedule and limiting charge amounts shown with 'C' indicates the technical component payment amount is **capped** at the OPPS amount." (Emph. added). Within those documents, all prices for the MRI procedure codes therein are clearly marked with a "C." As such, those MRI codes, by definition, are "capped at the OPPS amount," and are not the "full" fee schedule (i.e., participating fee schedule) amounts as created by 42 USC §1395w-4(b)(1) and (2). *See*, Plaintiff's Composite Exhibit 1, Tab 6, at p. 35 and 39. Rather, those amounts are capped at the OPPS (or OPD fee schedule) amount, and the limitations or restrictions set forth in the "Special rule for imaging services" of 42 USC §1395w-4(b)(4).

Conclusion

40. Based on the foregoing, the MRI Provider's motion for partial summary judgment is hereby **GRANTED**, and the Insurance Companies' joint motion for summary judgment is hereby **DENIED.** The Court hereby determines and declares as a matter of law that Section 627.736(5)(a)2.f, 3, and 4 do not authorize a PIP insurer to utilize the "Special rule for imaging services" of 42 USC §1395w-4(b)(4), the "OPPS" amount, or any other Medicare restrictions or limitations not expressly described by Section 627.736(5)(a)2.f, 3, and 4, when determining the amounts due for MRI services provided in the State of Florida to a PIP insured in a non-emergency, non-hospital setting since January 1, 2008.

41. This Court hereby reserves jurisdiction to determine the MRI Provider's remaining claims, and/or to determine claims for attorneys' fees and costs.

DONE AND ORDERED, in chambers, in Tampa, Hillsborough County, Florida, this 25th day of January, 2010.

Honorable James M. Barton, II
Circuit Court Judge

Conformed Copies to:
All counsel of record

091739

IN THE COUNTY COURT FOR
ORANGE COUNTY, FLORIDA

ERIC BRAVO, an individual by and through his assignee, ALTAMONTE SPRINGS DIAGNOSTIC IMAGING, INC. d/b/a MID FLORIDA IMAGING,

CASE NO. 2009-SC-235

Plaintiff,

v.

STATE FARM FIRE & CASUALTY COMPANY,

Defendant.
_____/

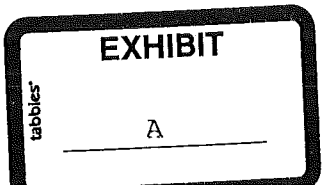
ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND FINAL JUDGMENT

THIS CAUSE, came before the Court on December 14, 2009, on Defendant's Motion for Summary Judgment, and the Court having reviewed the Motion for Summary Judgment, Applicable Law and hearing arguments of counsel finds that there are no material facts in dispute and Defendant, STATE FARM FIRE & CASUALTY COMPANY ("State Farm") is entitled to Final Judgment as a matter of law.

BACKGROUND/UNDISPUTED FACTS

State Farm insured Eric Bravo during the period of March 31, 2008 through July 24, 2008 under a personal auto policy. The personal injury protection policy provided $10,000.00 in PIP coverage and $5,000.00 in medical payments coverage.

On July 21, 2008, Eric Bravo was involved in an automobile accident. He and, through assignment of benefits, his assignees thereafter made claims for PIP and medical payments coverage. State Farm paid medical bills under the coverages.



On August 27, 2008, Eric Bravo received services at Mid-Florida Imaging which included the CPT Code 72158, an MRI of the lumbar spine without and with gadolinium contrast. Thereafter, Plaintiff submitted its bill for services which said bill was received by State Farm on September 12, 2008. The total amount submitted for CPT Code 72158 was $2,754.10. On September 24, 2008, State Farm issued payment to Mid-Florida Imaging in the amount of $1,245.20. This amount represented 200% of $622.60 which was the Outpatient Prospective Payment System (OPPS) amount listed under the Medicare Part B physicians' fee schedule. Additionally, on September 24, 2008, State Farm sent to Plaintiff an Explanation of Review detailing the reasons for the payment amount. The Explanation of Review set forth that effective January 1, 2007; Medicare capped the payment for the technical portion of the MRI at the Outpatient Prospective Payment System (OPPS).

On October 14, 2008, Mid-Florida Imaging sent a demand letter to State Farm seeking payment of the principal amount of $712.82. The demand letter was received by State Farm on October 17, 2008. On November 7, 2008, State Farm responded to Plaintiff's demand letter asserting that State Farm paid the subject bill in accordance with Medicare Part B and Fla. Stat. §627.736. The resulting lawsuit was filed on January 20, 2009 and State Farm was served through the Florida Department of Financial Services on January 22, 2009.

LEGAL ISSUE

The legal issue in this case involves the interpretation of Fla. Stat. §627.736 (5)(a)(2) and §627.736(5)(a)(3). More specifically, State Farm contends that the statutory phrase "allowable amount under the participating physicians fee schedule of Medicare Part B" refers to the actual amount allowed by Medicare under the published fee schedule and that the Outpatient Prospective Payments System (OPPS) adjustment or cap is expressly incorporated into the "allowable amount" under the fee schedule. State Farm asserts it properly paid the subject MRI bills at issue in accordance with Section 627.736(5)(a), Fla. Stat. More specifically, State Farm asserts that it paid the MRI provider according to the participating physician category under the Physician Fee Schedule of Medicare Part B which incorporates the Outpatient Prospective Payment System (OPPS) cap amount. State Farm argues that, for the reasons set forth herein, its Motion for Summary Judgment should be granted. It is Plaintiff's position that the Florida PIP Statute requires State Farm to calculate benefits in accordance with a specific fee schedule (i.e., the participating physicians fee schedule) and that the Outpatient Prospective Payment System (OPPS) cap does not apply.

Florida Statue §627.736 controls the payment for services such as MRIs. The relevant statutes state in part:

> (5) CHARGES FOR TREATMENT OF INJURED PERSONS.
>
> 2. The insurer may limit reimbursement to 80% of the following schedule of maximum charges:

> f. For all other medical services, supplies, and care, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. However, if such services, supplies or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or case is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.
>
> 3. For purposes of subparagraphs 2., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect at the time the services, supplies, or care was rendered and for the area in which such services were rendered, except that it may not be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.
>
> 5. If an insurer limits payment as authorized by subparagraph 2., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount of maximum policy limits.

Between 2001 and 2007, the Florida No-Fault Law required PIP insurers, like State Farm, to pay MRI providers for services to insureds an amount that was 80 percent of 200% of the 2001 Medicare Part B Participating Physician Fee Schedule published by Medicare, plus an annual "consumer price increase" adjustment. This payment system engendered substantial litigation over how it was to be applied. See Millennium Diagnostic Imaging Center, Inc. v. Security Nat. Ins. Co., 882 So. 2d 1027 (Fla. 3d DCA 2004); Clearview Imaging, LLC v. State Farm Mut. Auto. Ins. Co., 932 So. 2d 423 (Fla. 2d DCA 2006); Progressive Auto Pro Ins. Co. v. One Stop Medical, Inc., 985 So. 2d 10

(Fla. 4th DCA 2008); Altamonte Springs Imaging LC v. State Farm Mut. Auto. Ins. Co., 2009 WL 1531610 (Fla. 3d DCA 2009). The old No-Fault Law was abrogated in October, 2007.

State Farm argues that, unlike the prior law, the new No-Fault Law established a permissive fee schedule applicable to essentially all medical procedures. §627.736(5)(a)(2). Subsection (5)(a)(2), *supra,* states that an insurer "may limit reimbursement to 80 percent of the following schedules of maximum charges". Several of the fee schedules of "maximum charges" use the amount paid under the federal Medicare system as a baseline for calculating PIP insurance payments.

As they pertain to the instant case, the "maximum charges" reimbursed for MRI services also looks to the federal Medicare system as the baseline for calculating the PIP insurance payments. Subsection (5)(a)(2)(f) describes the methodology that a PIP insurer may use to limit reimbursement for "all other medical services, supplies, and care." It is undisputed that the MRI services at issue in this case were provided in a non-emergency, non-hospital setting, and therefore fall within the "other medical services" described in subsection (5)(a)(2)(f). For such services, the No-Fault Law provides that "maximum charges" a provider is reimbursed is "200 percent of the allowable amount under the participating physician's schedule of Medicare Part B." Fla. Stat. §627.736 (5)(a)(2)(f). Subsection (5)(a)(3) adds that, for purposes of subparagraph 2, "the applicable fee schedule...under Medicare is the fee schedule":

> "in effect at the time the services, supplies, or care was rendered and for the area in which such services were rendered, except that it may

> not be less than the allowable amount under the participating physicians' schedule of Medicare Part B for 2007."

In other words, the fee schedule for maximum charges for the current year must be compared to the schedule for 2007, and the higher of the two is to be paid to the provider.

State Farm contends that the "allowable amount" under the participating physicians schedule of Medicare Part B refers to the actual amount allowed by Medicare under the published fee schedule, and that the OPPS adjustment is expressly incorporated into the "allowable amount" under the fee schedule. As such, State Farm may apply the amount allowed by Medicare, including the OPPS amount, as a matter of law when it makes reimbursement payments to MRI providers pursuant to Fla. Stat. §627.736(5)(a)(2)(f).

The word "allowable", in common usage, means "permissible; not forbidden; not unlawful or improper." Sharp v. United States, 14 F. 3d 583, 587 (Fed. Cir. 1993)(citing Webster's Third New International Dictionary (1986)). "A fundamental canon of statutory construction is that unless otherwise defined, words will be interpreted as taking their ordinary, contemporary, common meaning." Perrin v. United States, 444 U.S. 37, 42 (1979). It is State Farm's position that the statutory reference to an "allowable amount" under the participating physicians fee scheduled refers to the "permissible" amount or "not forbidden" amount for that fee schedule. Thus, it is State Farm's position that the amount due under the fee schedule is the amount that is actually "allowed" to the provider by Medicare Part B. If the Florida Legislature had not intended to have the word "allowable" mean anything, it could have just as easily eliminated this word from

the statute. However, the word "allowable" is present and its placement is not viewed as an accident.

The court has reviewed the statute and finds that the language is clear and unambiguous and therefore applies the plain meaning rule. State Farm alternatively argued that even if the statute were not clear, the House Message Summary dated May 1, 2008 and the Florida Senate Bill Analysis and Fiscal Statement dated April 1, 2008 demonstrates the legislature's intent to have insurer pay 200% of what Medicare would pay to a participating physician. The summaries state:

> The bill clarifies that insurers' reimbursement for medical services would be based on 200 percent of the applicable Medicare Part B fee schedule "for participating physicians."
>
> Under Medicare Part B, a participating physician accepts Medicare's allowed charge as payment in full for all of their Medicare patients.

The court reviewed Fla. Stat. §§ 627.736(5)(a)(2)(f), (5)(a)(3); 42 USC §1395w-4 which establishes the Medicare Part B fee schedule; Section 5102 of the Deficit Reduction Act of 2005 amending 42 USC §1395w-4(C)(2)(B); a report of the United States Government Accountability Office regarding Medicare Trends in Fees at GAO-08-1102R (Medical Imaging Payments); 71 F.R. 69624-01; 72 F.R. 66222-01; CMS PFS National Payment Amount File; First Coast Service Options 2007 & 2008 Fee Schedules for CPT Code 72158; Medicare Part B Updates dated December 2006 Volume 4 Number 9; March 2007 Special Issue Update; CMS Physician Fee Schedule Search page for CPT 72158; and the Affidavit of Mirta Rosado.

State Farm argued that the amount allowed by Medicare Part B and paid to its participating physicians for CPT Code 72158 in year 2008 is $622.50. The Court compared the 2007 rate for the same code ($587.10). Since the 2007 amount is not greater than 2008, the statute requires payment of the 2008 amount. Here State Farm paid $1,245.20 or 200% of $622.60.

In summary, State Farm argued that under the Medicare statutory scheme, CMS regulations, and actual practice, the "allowable amount" under the participating fee schedule for Medicare Part B is capped at the OPPS amount. As Medicare applies the OPPS adjustment, so should Florida PIP insurers, as they calculate the reimbursement amount required by §627.736(5)(a)(2)(f). Here, State Farm calculated the "allowable amount" in exactly the same way Medicare did; in accordance with the plain meaning of §627.736(5)(a)(2)(f). State Farm used the appropriate calculation methodology and its motion for summary judgment is therefore granted. This Court recognizes and adopts the analysis and reasoning of the Honorable Robert W. Lee in MRI Services, I, LLC d/b/a C & R Imaging of Hollywood as assignee of Yunono Baranovskaya v. Mercury Insurance Company, 17 Fla. L. Weekly Supp. 46a (Cty. Crt., 17th Jud. Cir., Broward County, November 4, 2009).

IT IS, THEREFORE, ADJUDGED AND DECREED AS FOLLOWS:

Final Judgment be and the same is hereby entered in favor of Defendant, STATE FARM FIRE & CASUALTY COMPANY and against Plaintiff, ERIC BRAVO, an

individual by and through his assignee, ALTAMONTE SPRINGS DIAGNOSTIC IMAGING, INC. d/b/a MID FLORIDA IMAGING.

Plaintiff, ERIC BRAVO, an individual by and through his assignee, ALTAMONTE SPRINGS DIAGNOSTIC IMAGING, INC. d/b/a MID FLORIDA IMAGING, takes nothing by this action and Defendant, STATE FARM FIRE & CASUALTY COMPANY, shall go forth without day.

DONE AND ORDERED this 19th day of April, 2010 in Orlando, Orange County, Florida.

s/ JOHN E. JORDAN

JOHN E. JORDAN
County Judge

Copies furnished to:
John L. Morrow, Esq., Attorney for Defendant, Orlando
Michelle Kelson, Esq., Attorney for Plaintiff, Orlando