IN THE THIRTEENTH CIRCUIT COURT
FOR HILLSBOROUGH COUNTY, FLORIDA
APPELLATE DIVISION

TAMPA TRAUMA MEDICAL CENTER, INC., a/a/o Carlos O. Gonzalez,

Appellant,

vs.

STATE FARM FIRE AND CASUALTY COMPANY,

Appellee.

Appeal no.: 08-28255
Division: X
County ct. case no.: 05-27646-CC

On review of a final judgment of the County Court for Hillsborough County, Florida.
The Hon. Paul Huey, County Court Judge, presiding.

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Opinion filed Oct 26 **, 2009.**

This case is before the court to review a judgment entered in favor of State Farm and against Tampa Trauma Medical Center. State Farm's insured Carlos Gonzalez suffered injuries in an automobile accident and assigned his benefits to Tampa Trauma (hereinafter "provider") after he sought treatment for his injuries at the clinic. The provider challenges the judgment on a number of issues, the primary one being that State Farm inappropriately exhausted benefits paying claims that arose while the instant provider's claims were under investigation. The provider contends that State Farm paid benefits out of turn to another provider and then neither notified it that benefits were exhausted nor provided an explanation of benefits for its denial of the claims. State Farm contends it did not owe additional benefits for several reasons including exhaustion, and because benefits had been exhausted, it was not legally required to provide an explanation of benefits. The trial court entered judgment in State Farm's favor without discussing the propriety of its decision to pay a later filed claim. After the trial judge awarded attorney's fees to State Farm, the provider timely filed this appeal. We agree with the trial court's decision because a) State Farm had legitimate reasons to delay payment to this provider to investigate questionable claims; b) because of the foregoing it was not wrong for State Farm to pay uncontested later filed claims, thereby exhausting benefits; and c) State Farm is not liable for benefits over and above those contracted for by State Farm and its insured. The facts are as follows.

As a result of injuries he sustained in a December 21, 2004 automobile accident, State Farm's insured Carlos Gonzalez sought treatment at the provider's clinic. Between December 27, 2004 and April 13, 2005, the provider billed for claims related to treatment of insured pursuant to assignment. Notwithstanding the provider's assertion to the contrary in its initial brief, State Farm did pay many, though not all, claims during this period. On March 9, 2005, State Farm made its final payment on above claims before State Farm began investigating them. Payments State Farm made amounted to over $7000 out of $10,000 available benefits. But on or about March 9, 2005, State Farm noted significant irregularities in records from the provider's clinic, not just on the instant insured, but also on others. According to a State Farm witness, there were other indicators of potentially significant problems with the claims, and these triggered the investigation to ascertain whether State Farm actually owed for the claimed treatment.

Pursuant to its investigation, on April 12, 2005, State Farm sent letter to the provider that its claims were being investigated and requested further information. Fifty days later, around June 1, 2005, the provider's attorney responded to the foregoing letter, but incompletely. On or about June 16, 2005, State Farm sent follow up letter seeking the missing information. The provider responded with more information on June 24th.

On August 18, 2005, State Farm exhausted benefits paying the claim of another provider who rendered treatment to the insured for injuries related to the accident. The amount paid was partial: $110.18 of a $500 claim. Admittedly, this was paid after the instant provider's claims were submitted and before they were formally denied. At the time benefits were exhausted paying other claims, State Farm had not completed its investigation, although it appears that State Farm would have denied further benefits at the conclusion of its investigation.

On September 15, 2005 the provider's attorney sent the required statutory demand letter pursuant to §627.736(11), Florida Statutes, seeking payment of $5451. Prior to its demand letter, the provider had received over $7000 of the available $10,000, so the provider should have known this request exceeded available benefits, even if no outside payments had been made. On September, 30, 2005, State Farm responded, again advising that the claims were being investigated, despite the fact that benefits had been exhausted by that time. State Farm's investigator testified that he didn't know benefits were exhausted when he sent the response, as he handles investigations only. On the other hand, counsel for the provider never inquired as to the availability of benefits, despite having been paid over 70 percent of the benefits and the passage of at least five month's time since the provider last received any payment. Still, approximately seven months after the last claims, and about three months after the exhaustion of benefits, in November, 2005, the provider filed suit against State Farm.

In determining that benefits had not been inappropriately exhausted, the trial court reviewed deposition testimony of State Farm's representative from its Special Investigative Unit, Robert Lastres. Lastres testified at deposition that State Farm had reasonable proof to not make additional payment over the $7,000 already paid and needed to conduct further investigation due to serious concerns over the provider's bills. State Farm moved for summary judgment on Count I based on pre-suit exhaustion of Mr. Gonzalez's PIP benefits. State Farm advised the court that benefits were exhausted by the single payment of $110.80 to Martinez, P.A. approximately one month before the provider submitted the required demand letter to State Farm and approximately three months before suit was filed.

The provider moved for summary judgment on Counts II and III asserting that State Farm did not provide an Explanation of Benefits, commonly referred to as EOB, or seek additional information pursuant to §§627.736(4)(b) and (6)(b), Florida Statutes. After an extensive hearing,

the trial court granted State Farm's motion for summary judgment on Count I, based on the exhaustion defense and denied the provider's motion as to Counts II & III. The court's October 23, 2007 order granting motion for summary judgment stated that Counts II & III remain "causes of action."

Later the court determined that the provider was not entitled to summary judgment. As to Count II, the court determined as a matter of law that no EOB was required "because there was no rejection of benefits or termination or reduction of benefits." The court also found for State Farm as to Count III. State Farm stated it would be filing motions for summary judgment on the remaining two counts.

Although State Farm had not yet moved for summary judgment on those two pending counts, the provider nevertheless submitted, on October 3, 2008, a proposed order disposing of all issues, including the two counts on which the court had not yet ruled with finality in favor of State Farm. The court signed the provider's proposed order, which certified "as a matter of great public importance" this question:

> WHEN AN INSURER DOES NOT PAY A PORTION OF A CLAIM OR REJECT A CLAIM WITHIN 30 DAYS, DOES IT, PURSUANT TO FLORIDA STATUTE §627.736(4)(b), HAVE TO PROVIDE AN ITEMIZED SPECIFICATION OF EACH ITEM THAT THE INSURER HAD REDUCED, OMITTED, OR DECLINED TO PAY AND ANY INFORMATION THAT THE INSURER DESIRES THE CLAIMANT TO CONSIDER RELATED TO THE MEDICAL NECESSITY OF THE DENIED TREATMENT OR EXPLAIN THE REASONABLENESS OF THE RELATED CHARGE? [1]

The Second District Court of Appeal declined to exercise discretionary jurisdiction over the certified question and transferred the appeal to this court. Now that appeal has been taken from the final judgment, we may review, *de novo,* the antecedent denial of the provider's summary judgment. Tiger Point Golf and Country Club v. Hipple, 977 So.2d 608, 610 (Fla. 1st DCA 2007). The standard of review is also *de novo* for the granting of summary judgment in State Farm's favor. Volusia County v. Aberdeen at Ormond Beach L.P., 760 So. 2d 126, 130 (Fla. 2000).

On appeal, only two of the myriad substantive issues the provider raises merit any discussion.[2]

Count I of the complaint (including amendments) sought payment of over $5400.00 in unpaid medical bills. Because of the exhaustion of benefits, the trial court was correct to enter summary judgment in State Farm's favor. Am. Ins. Co. v. Stand-Up MRI of Orlando [Stand-Up MRI], 990 So. 2d 3, 4 (Fla. 5th DCA 2008)(a PIP insurer is not liable for benefits once benefits have been exhausted). An insurer's payment of the full PIP policy limits is a defense to a PIP suit in the absence of an allegation and showing of bad faith. Id. In this case, PIP coverage was exhausted about a month before the provider sent a demand letter to State Farm, pursuant to §627.736(11)(a), Florida Statutes. There was no allegation in the complaint or evidentiary

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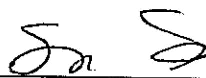
[1] A typographical error is contained in the Summary Judgment. The next to the last word in the certified question should have read "REDUCED" instead of "RELATED."

[2] On a procedural level, the provider argues that the trial court erred when it allowed State Farm to amend its answer and affirmative defenses to include exhaustion of benefits. The trial court was correct to allow amendment, and its decision is consistent with this court's decision in United Auto Ins. Co. v. Diag. Med. Ctr., 15 Fla. L. Weekly 967a (Fla. 13th Cir. 2008).

showing of bad faith, which is essential to a claim for benefits over and above policy limits. With regard to the alleged out-of-turn payments, this issue lacks merit. Florida insurance law does not adopt the English Rule order of payment scheme where the basis for paying claims ahead of a previously submitted one is to investigate the insurer's liability to the earlier claim. Stand Up MRI at 5-6 (there is no legal requirement that an insurer set aside a reserve fund for claims which are reduced or denied; it is first come-first served for medical providers as long as their PIP claim is deemed to be compensable). (Emphasis ours.) See also Robert D. Simon, M.D., P.A. v. Progressive Exp. Ins. Co., 904 So. 2d 449 (Fla. 4th DCA 2005)(insurer not required to set aside a reserve fund for claims that were reduced or denied).

With regard to Count II, the provider asserts that State Farm breached its duty to send it information (commonly called an "explanation of benefits" or EOB) pursuant to §627.736(4)(b), Florida Statutes. Summary Judgment was proper as a matter of law primarily because the insured's PIP benefits were already exhausted before suit was filed and the statutory demand letter was served; therefore, State Farm had no further liability. Because benefits had been exhausted, the EOB requirement in §627.736(4)(b) was not triggered. The plain language of §627.736(4)(b) provides that an EOB is required only when an insurer rejects outright or partially pays a claim. That did not occur here.

It is therefore **ORDERED** that the decision of the trial court is **AFFIRMED.** It is further **ORDERED** that Tampa Trauma's motion for appellate attorney's fees is **DENIED.** As the prevailing party, State Farm's motion for appellate attorney's fees is **GRANTED,** conditioned upon the trial court's determination that the relevant proposal for settlement is valid, this 24 day of Oct, 2009.

By: 

Susan Sexton, Presiding Circuit Judge

PENDINO and HONEYWELL, JJ., Concur.