IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

CASE NO. 0:16-cv-62610-BLOOM/Valle

A&M GERBER CHIROPRACTIC, LLC
a/a/o Conor Carruthers on behalf of itself
and all others similarly situated,

Plaintiff,

v.

GEICO GENERAL INSURANCE
COMPANY,

Defendant.
_____/

PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT

Plaintiff, A&M GERBER CHIROPRACTIC, LLC ("Plaintiff" or "Gerber") by and through undersigned counsel hereby files its Motion for Partial Summary Judgment, and in support states:

INTRODUCTION

In this case, no material facts remain in dispute. The relevant GEICO insurance policy endorsement ("GEICO Policy") at issue, which provides Personal Injury Protection ("PIP") coverage mandated by Section 627.73, Florida Statutes ("PIP Statute") [D.E. 27-1],[1] and the relevant facts concerning Defendant's reason for reducing reimbursement to Plaintiff are established. The parties' interpretations of GEICO's Policy remain however clearly at odds. The Court can now rule as a matter of law on whose interpretation is correct.

[1] The policy endorsement at issue is attached to the Complaint as Exhibit A [D.E. 23-1]. Plaintiff cites the version Defendant placed in the record [D.E. 27-1], because it is a clearer copy, and it is the official version of the GEICO Policy on file with the Florida Office of Insurance Regulation.

Accordingly, in this motion, Plaintiff simply asks the Court to enter a partial summary judgment[2] on the proper interpretation of the GEICO Policy. Based on the following, the Court should grant this motion in Plaintiff's favor unequivocally.

STATEMENT OF UNDISPUTED FACTS
(S.D. FLA. L. R. 56.1(a))

1. Defendant GEICO GENERAL INSURANCE COMPANY ("GEICO" or "Defendant") provides automobile insurance throughout the State of Florida, is registered to do business in Florida, and transacts business in Broward County, maintaining an office and representatives there from where it continues to transact insurance business [D.E. 52 at ¶ 3].

2. Plaintiff is Florida Limited Liability Company, which through its managing member, chiropractor Michael E. Gerber, provides medical services and supplies in Florida [D.E. 1-5 at ¶ 3a-b; DE 46 at 1; D.E. 53-1 at ¶¶ 2-3].

3. Defendant has filed in the Court's record an exact, authentic, and legible copy of the GEICO insurance policy endorsement ("GEICO Policy") at issue in this case. *See* D.E. 52 at ¶ 10; D.E. 27 at ¶ 2; D.E. 27-1; *see also* D.E. 46 at 2 (stating "[a] copy of the *applicable* policy is at ECF No. [27-1]") (emphasis added).

4. The GEICO Policy provides among other things for Personal Injury Protection ("PIP") insurance under Section 626.736, Florida Statutes [D.E. 27-1 at 4].

5. In the GEICO Policy, GEICO has elected the fee schedules referred to in Section 626.736(5)(a)1. a-f, Florida Statutes [D.E. 23 at ¶ 7; D.E. 27-1 at 4].

6. The GEICO Policy is identified by the alphanumeric identifier—"FLPIP (01-13)"–– and includes the following statement among others:

> A charge submitted by a provider, for an amount less than the amount allowed above, shall be paid in the amount of the charge submitted.

[2] Plaintiff's motion for class certification remains pending. D.E. 53.

[D.E. 23 at ¶ 10; D.E. 27-1 at 4].

7. This endorsement identified by "FLPIP (01-13)" has been in force for GEICO PIP policies that were first written or renewed after January 2013 [D.E. 37 at 5; D.E. 52-2 at 23].

8. The terms of the GEICO Policy including the above-quoted provision have remained unchanged since they become in force [D.E. 23 at ¶ 21; D.E. 37 at 13].

9. The GEICO Policy is part of an insurance contract. *See* D.E. 9 at ¶ 9 (referring to the GEICO Policy as the "contract at issue"); *see also* § 627.402 (3), Fla. Stat. (defining "policy" to be "a written contract of insurance or written agreement for or effecting insurance").

10. GEICO issued a Florida PIP insurance policy to Conor Carruthers, which includes the above-quoted GEICO Policy language GEICO incorporates by the endorsement identified by FLPIP (01-13) [D.E. 34 at 3; D.E. 53-1 at ¶ 3].

11. Plaintiff is a health care provider, who in March 2015 provided health care services to Conor Carruthers for injuries he suffered in an automobile collision [D.E. 1-5 at ¶ 3a-b; DE 46 at 1; D.E. 53-1 at ¶¶ 2-3].

12. Plaintiff accepted an assignment of insurance benefits from Mr. Carruthers relating to the GEICO Policy GEICO issued to Mr. Carruthers [D.E. 53-1 at ¶ 3].

13. Plaintiff sent HCFA 1500 forms to GEICO showing charges for the treatment Plaintiff rendered to its insured, Mr. Carruthers [D.E. 53-1 at ¶ 3]. Specifically, Plaintiff billed $60 for CPT Code 97110 and $45 for CPT Code 97140 [Id.]. Both charges are less than the elected fee schedule in the GEICO Policy [Id.]. GEICO only paid $48 and $36 respectively [Id.]. For each one of these payments, Plaintiff received an Explanation of Review from GEICO indicating that his payments were reduced based on the code "BA" [Id.]. See D.E. 53 at n. 6, 8 (defining HCFA and CPT).

14. "Explanation Code BA" is a reason code used to explain the reimbursement amount for medical services and supplies charged to an insured by a medical provider [D.E. 1-5 at ¶ 3d; D.E. 53-2, Deposition of David Antonacci ("Antonacci Dep.") at 20:10-12].

15. This reason code "BA," according to GEICO, indicates GEICO has reduced the reimbursements to the health care provider by paying the provider only 80% of the amount the provider billed for claims made under the GEICO Policy [Antonacci Dep. at 20:14-22, 21:1-13; DE 1-5 at ¶ 7].

16. Plaintiff maintains that under the above-quoted GEICO Policy language GEICO incorporates by the endorsement FLPIP (01-13), stating "[a]charge submitted by a Provider, for an amount less than the amount allowed above [i.e. the amount permitted under the disclosed fee schedule], shall be paid in the amount of the charge submitted"—means that if a healthcare provider (including Plaintiff) charges an amount less than an applicable fee schedule amount, GEICO must pay the entire amount reasonably charged by the provider for medically necessary services rather than just 80% of the billed amount [D.E. 23 at ¶ 11; D.E. 53-1 at ¶ 4].

17. GEICO on the other hand maintains that the GEICO Policy only requires it to reimburse at 80% of such charge billed without regard to whether the charge was above or below any applicable fee schedule amount [D.E. 46 at 15].

18. At the time that the treatment was rendered to the Plaintiff, 200% of the Medicare Part B payment amount for CPT Code is 97110 is $67.04 and for CPT Code 97140 is $61.44. See Todd Payne, Declaration.

19. Even though the amount Plaintiff billed for CPT Codes 97110 and 97140 were less than the disclosed fee schedule amounts, GEICO only paid Plaintiff 80% of the amount billed to reduce the amounts paid to the Plaintiff for those CPT codes to $48.00 and $36.00 respectively.

[D.E. 23 at ¶¶14-15; D.E. 52 at ¶ 36; and D.E. 52-2 at 53-60 (stating "THE ABOVE WAS PAID AT 80%)].

LEGAL STANDARDS

Summary judgment Standards. Summary Judgment "is properly regarded…as an integral part of the Federal Rules as a whole, which are designed to secure the just, speedy[,] and inexpensive determination of every action." *Pace v. Capobianco*, 283 F.3d 1275, 1284 (11th Cir. 2002). Summary judgment is properly granted when "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a).

For and against summary judgment, the parties may support their positions by citation to the record, including, depositions, documents, affidavits, or declarations. Fed. R. Civ. P. 56(c). Under Rule 56, "[a]n issue is genuine if 'a reasonable trier of fact could return judgment for the non-moving party.'" *Black Knight Prot., Inc. v. Landmark Am. Ins. Co.*, No. 13-22838-CIV, 2014 WL 11638574, at *3 (S.D. Fla. Dec. 30, 2014) (citations and quotations omitted). "A fact is material if it 'might affect the outcome of the suit under the governing law.'" *Id.* (citations and quotations omitted). The court views the facts in a favorable light to the non-moving party and draws reasonable inferences it that party's favor. *Id*. (citing *Davis v. Williams*, 451 F.3d 759, 763 (11th Cir. 2006)).

The moving party must support summary judgment "with evidence on which a jury could reasonably find for the plaintiff." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986). The moving party bears the burden of showing the absence of a genuine issue of fact. *Id.* Once it does so, the nonmoving party must do more than express doubt as to material facts; it "must produce evidence, going beyond the pleadings, and by its own affidavits, or by depositions,

answers to interrogatories, and admissions on file, designating specific facts to suggest that a reasonable jury could find in the non-moving party's favor." *Id.* (citing *Shiver v. Chertoff*, 549 F.3d 1342, 1343 (11th Cir.2008)). In ruling on summary judgment, the court is however not to weigh conflicting evidence. *Certain Underwriters at Lloyds, London Subscribing to Policy No. SA 10092-11581 v. Waveblast Watersports, Inc.*, 80 F. Supp. 3d 1311, 1316 (S.D. Fla. 2015) (citations omitted).

Policy Interpretation Standards. "The interpretation of insurance policies, like the interpretation of all contracts, is generally a question of law." *Goldberg v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA.*, 143 F. Supp. 3d 1283, 1292 (S.D. Fla. 2015) (citations omitted). The "Florida Supreme Court has made clear that the language of the policy is the most important factor…" *Id*. Florida law provides when the language in an insurance contract is clear and unambiguous, a court must interpret the policy in accordance with its plain meaning. *Washington Nat'l Ins. Corp. v. Ruderman*, 117 So.3d 943, 948 (Fla. 2013). If, however, the language is susceptible to more than one reasonable interpretation, then the language is ambiguous and is to be construed strictly against the insurer and in favor of insured. *See id; see also Flores v. Allstate Ins. Co*., 819 So.2d 740, 744 (Fla. 2002).

Along these lines, as the drafter of the policy, the insurance company "is bound by the language of the policy, which is to be construed liberally in favor of the insured and strictly against the insurer." *Berkshire Life Ins. Co. v. Adelberg*, 698 So. 2d 828, 830 (Fla. 1997)). This is the rule no matter whether under the language of the policy, the insurance company has struck a good or bad bargain for the insurer. *Id*. If the insurance company meant something different from the plain text of the policy, then it is required to unambiguously draft the contract accordingly. *Id*. Courts are not permitted to revise an otherwise valid insurance policy to make it more reasonable or

advantageous for an insurance company that used imprecise language providing coverage that is greater than coverage the insurance company may have originally contemplated. *Stack v. State Farm Mut. Auto. Ins. Co.*, 507 So.2d 617, 619 (Fla. 3d DCA 1987). In short, the insurer not the insured bears the risk of poorly drafted or imprecise language.

Moreover, as with any contract or statute, context is a permissible indicator of meaning. *See generally* Antonin Scalia & Bryan A. Garner, Reading Law: An Interpretation of Legal Texts (2012). Courts may rely on dictionary definitions to interpret policies. *Barcelona Hotel, LLC v. Nova Cas. Co.*, 57 So. 3d 228, 231 (Fla. 3d DCA 2011). And Florida law provides that an insurance contract is to be "construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended, or modified by any application therefor or any rider or endorsement thereto." § 627.419(1), Fla. Stat.

The plain meaning of the disputed text in context is therefore paramount and controlling.

ARGUMENT

I. Textual Analysis of the Policy Supports Plaintiff's Interpretation.

Courts interpret insurance policies as a matter of law. There is no genuine dispute that under the standards for policy construction in Florida, the GEICO Policy at issue, stating—"[a] charge submitted by a provider, for an amount less than the amount allowed above, shall be paid in the amount of the charge submitted"—means what it states: When a health care provider bills for covered services at an amount less than 200% of the fee schedule—either Medicare or Workers Comp (depending on the CPT code)—Defendant is required to pay the charge as billed without reduction attributable to 80% of the amount charged.

A. Text of the Policy

The text at issue appears in the Section of the GEICO Policy titled "Payments We Will Make." GEICO begins the Section, referring to GEICO's payment of 80% of the charges billed, "*pursuant to* the…schedules of maximum charges" in the PIP Statute, stating it will pay:

> (A) Eighty percent (80%) of ***medical benefits*** which are ***medically necessary,***" pursuant to the following schedule of maximum charges contained in the Florida Statutes § 627.736(5)(a)1., (a)2. and (a)3.:
>
> 1. For emergency transport and treatment by providers licensed under Florida Statutes, chapter 401, 200 percent of Medicare.
>
> 2. For emergency services and care provided by a hospital licensed under Florida Statutes, chapter 395, 75 percent of the hospital's usual and customary charges.
>
> 3. For emergency services and care as defined by Florida Statutes, § 395.002 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.
>
> 4. 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.
>
> 5. 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.
>
> 6. For all other medical services, supplies, and care, 200 percent of the allowable amount under:
>
> (I.) The participating physicians fee schedule of Medicare Part B, except as provided in sections (II.) and (III.) (II.) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.
>
> (III.)The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

D.E. 27-1 at 4 (underlying added, otherwise emphasis in original). Immediately following this numbered list, in the same Section, GEICO adds as series of specific qualifications and conditions in separate paragraphs on what and how it will pay, stating,

> However, if such services, supplies, or care is not reimbursable under Medicare Part B (as provided in section (A) 6. above), we will limit reimbursement to eighty percent (80%) of the maximum reimbursable allowance under workers' compensation, as determined under Florida Statutes, § 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 us.
>
> The applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.
>
> We may use the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.
>
> A charge submitted by the provider, for an *amount less than the amount allowed above*, **shall be paid** *in the amount of the charge submitted*. (emphasis added)
>
> Within 30 days after receiving notice that the Medicaid program has paid ***medical benefits***, we shall repay the full amount of the **medical benefit**s to the Medicaid program subject to the **LIMIT OF LIABILITY**. (emphasis in original)

D.E. 27-1 at 4 (emphasis in next-to-last last sentence added; other emphasis in original).

B. Analysis of the GEICO Policy Text

The interpretation at issue in this case is primarily the meaning of "an *amount less than the amount allowed above*" (italicized in the next-to-last paragraph quoted above) and whether that language refers to 200% of the Medicare Part B Fee Schedule or means something else. The answer is in the clearly worded text. Indeed, after the introductory sentence of the Section "(A)," GEICO adds further definition to what it will pay in a numbered list, including treatment for ordinary medical services, like the service provided in this case, at "200 percent of the allowable amount under" the Medicare Fee Schedule. After this list, it adds several other qualifications and

conditions. Reading the two sections together, it is clear what Defendant meant by "the amount allowed above." And for treatment like ordinary medical care, "the amount allowed above" is 200% of the Medicare Fee Schedule.

Note that the paragraph at issue—"[a] charge submitted by the provider, for an amount less than the amount allowed above, shall be paid in the amount of the charge submitted"—is *not* part of the preceding list or any other conditioning subparagraph: It stands alone as a separate paragraph. It refers specifically to "the amount allowed above," echoing GEICO's reference to the phrase "allowable amount" in the preceding text above, when it refers to "200 percent of the allowable amount" under fee schedules. Thus, when GEICO states the condition that "[a] charge submitted by a provider such as Plaintiff, for an amount less than *the amount allowed above*, **shall be paid** in the amount of the charge submitted" (emphasis added)—considering the overall context in which this paragraph appears, the plain meaning of the text is exactly what it says: When a health care provider bills for covered services at an amount less than 200% of the fee schedule—either Medicare or Workers Compensation (depending on the CPT code)—Defendant is required to pay the charge as billed without reduction attributable to 80% of the amount charged. Moreover, GEICO states no limitation in this condition to reimbursement at 80% of the charges submitted, while it specifically does so when payments are made "*pursuant to* the…schedule of maximum charges contained in the Florida Statutes § 627.736(5) (a)1., (a)2. and (a)3" (emphasis added); and when GEICO "limit[s] reimbursement to eighty percent (80%) of the maximum reimbursable allowance under workers' compensation," when covered care is not reimbursable under Medicare Part B.

The ordinary meaning of the word "shall" is "[h]as a duty to; [or] more broadly, is required to." SHALL, Black's Law Dictionary (10th ed. 2014) (Westlaw). Thus, based on the foregoing text

read as a whole and the wording of the specific text at issue, Plaintiff submits that GEICO, has obligated itself to pay 100% of the charges when they are at an amount less than the fee schedule reimbursement amounts. Accordingly, when Plaintiff submitted its charge for CPT Code 97110 in the amount of $60.00 (which is less than 200% of the Medicare fee schedule amount of $67.04), under the GEICO Policy, GEICO was required to pay Plaintiff "in the amount of the charge submitted" or $60.00. Likewise, when Plaintiff submitted its charge for CPT Code 97140 in the amount of $45.00 (which is less than 200% of the Medicare Fee schedule amount of $61.44), the GEICO Policy required that GEICO pay Plaintiff "in the amount of the charge submitted" or $45.

II. GEICO's Interpretation of Its Policy as Expressed In this Case is Wrong.

In prior filings in this case, GEICO's interpretation and Plaintiff's interpretation have been clearly at odds. GEICO's interpretation has been that both the PIP Statute and the GEICO Policy [D.E. 27-1] authorize it to pay 80% of charges that are less than 200% of the allowable Medicare (or other statutorily enumerated) fee schedule rates. *See, e.g.* D.E. 47 at 15-16. Specifically, GEICO contends that the preamble to GEICO's payment section titled "WHAT WE WILL PAY" recognizes that it "will pay in accordance with the Florida Motor Vehicle No Fault Law" ("PIP Statute") and, where applicable, in accordance with all fee schedules" in that PIP Statute, Sections 627.736(5) (a)1., (a)2. and (a)3. [D.E. 27-1 at 4]. GEICO then launches into an analysis of the history of the PIP Statute, D.E. 47 at 18-21. GEICO's interpretation is wrong in several respects.

A. GEICO's Interpretation Ignores the Plain Language of its Policy.

First, GEICO does not challenge Plaintiff's interpretation of the actual wording of GEICO's own insurance policy, rather it attempts to inject other language in the policy from legislative history to support its own interpretation. Without discussing the actual language GEICO wrote in its own policy, GEICO argues because the PIP Statute has historically

incorporated a 20% coinsurance burden on the insured, its policy does so too. While it is correct that a court may interpret the GEICO considering the PIP Statute, it is not correct that in doing so it may ignore what the GEICO Policy actually says.

It is well settled that courts may not "rewrite contracts, add meaning that is not present, or otherwise reach results contrary to the intention of the parties." *Intervest Const. of Jax, Inc. v. Gen. Fid. Ins. Co.*, 133 So.3d 494, 497 (Fla. 2014) (quoting *State Farm Mut. Auto. Ins. Co. v. Pridgen*, 498 So.2d 1245, 1248 (Fla. 1986)). But that is exactly what GEICO is asking this Court to do by reading a co-insurance obligation into the GEICO Policy where none exists. The GEICO Policy plainly states that "a charge submitted by a provider, for an amount less than the amount allowed above [i.e. "*pursuant to* the…schedules of maximum charges" contained in the PIP Statute as qualified by subsequent paragraphs], ***shall be paid in the amount of the charge submitted.*"** (emphasis added). Absent from this language in dispute is that charges that are less than the amount allowed will be paid at eighty percent (80%) as specifically provided for the "schedule of maximum charges" or the "workers compensation" fee schedules. To the contrary, the language has no limitation and recognizes that the provider will be paid in the amount of the actual charge submitted. Accordingly, to accept GEICO's interpretation of its own policy, the Court must rewrite the policy to say that if the charge is less than the amount allowed, the provider "shall be paid **eighty percent (80%) of the amount of the charge submitted."** This is simply not the language used by GEICO and should not be allowed.

B. GEICO's Interpretation Ignores that PIP Sets a Statutory Coverage Minimum.

Second, GEICO misunderstands that the PIP Statute does not limit coverage an insurer can provide: It only sets a mandatory minimum of coverage. Hence, as an insurance contract, a PIP insurance policy may provide greater coverage than the amount required by the PIP Statute. *DCI*

MRI, Inc. v. Geico Indem. Co., 79 So. 3d 840, 842 (Fla. 4th DCA 2012). In that case, "the terms of the policy…control" the method of calculating reimbursements of claims made under the policy. *See id.* (quoting *Kingsway Amigo Insurance Co. v. Ocean Health, Inc.*, 63 So.3d 63, 68 (Fla. 4th DCA 2011)). Under Florida law "where a policy provides coverage beyond any limitation in the [insurance] code, the court must enforce the terms of the contract as written." *Allen v. USAA Cas. Ins. Co.*, 790 F.3d 1274, 1283 (11th Cir. 2015). GEICO therefore cannot escape the language it wrote, even though the PIP Statute may have historically imposed a 20% coinsurance limitation on insureds.

C. Plaintiff's Interpretation is Consistent with the PIP Statute.

Third, GEICO is wrong that Plaintiff's interpretation violates the PIP Statute. As detailed in the Plaintiff's pending Motion for Class Certification [D.E. 53 at 4-6], the PIP Statute has been a work in progress for over 40 years. It is constantly amended for various reasons. In 2007, PIP was subject to a sunset for a couple of weeks, but then was reenacted. Upon reenactment, the legislature provided insurers the opportunity to adopt into their policies a specific payment methodology that utilized the Medicare and Workers Compensation fee schedules to determine the proper amounts to pay to healthcare providers.

GEICO has attempted to utilize language like the language in its current policy in the preamble quoted above to limit its payment obligations to health care providers. In *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*, 141 So. 3d 147, 155-57 (Fla. 2013), for instance, the Florida Supreme Court determined that the fee schedule in the statute was permissive because of the use of the word "may" in its description, and for an insurance company to utilize the fee schedules it was required to put the proper notice in its insurance policy concerning the use of the

fee schedule. This decision followed similar intermediate appellate court decisions including *Kingsway v. Ocean Harbor Ins. Co.*, 63 So.3d 63 (Fla. 4th DCA 2011).

In 2012, after *Kingsway,* and before the opinion in *Virtual Imaging,* the legislature enacted legislation recognizing that the fee schedule was permissive. This language is found in Section 627.736 (5)(a)5 and provides as follows: "An insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph." In the same legislation and subsection, the legislature added that "[i]f a provider submits a charge for an amount less than the amount allowed under subparagraph 1,[3] the insurer may pay the amount of the charge submitted."

GEICO reads this language as permitting insurance companies to pay "lower amounts in situations where the providers charge less than he (sic) fee schedule rates" [D.E. 46 at 18]. However, this language establishes the contrary: The use of the word "may" in the statute indicates that this provision, like the fee schedule itself, is not mandatory and use of this provision in an insurance policy is optional. Further, the language recognizes if the amount of a charge is less than the amounts in subparagraph 1—essentially 200% of Medicare or Workers Compensation—then "it may pay the amount of the charge submitted." Again, as with the policy language itself, the statutory language does not limit payment to 80% of the charge submitted. In short, the PIP Statute permits an insurance company to include in its policy a provision that if a provider submits a bill for less than the fee schedule amount, the insurance company may pay the amount charged. The disputed language in the GEICO policy does just that.

[3] Subparagraph 1 provides: "[t]he insurer may limit reimbursement to 80 percent of the following schedule of maximum charges" and then lists several fee schedules.

Moreover, there is nothing in the statute text or legislative history that prevents GEICO from waiving the 20% copay as it sees fit. As stated above, under Florida law, "an insurance company is not precluded from offering greater coverage than that is required by the statute." *Kingsway v. Ocean Harbor*, 63 So.3d 63 (Fla. 4th DCA 2011) (quoting *State Farm Florida Insurance Co. v. Nichols*, 21 So.3d 904 (Fla. 5th DCA 2009)). In short, waiving a copay is not illegal or in violation of the PIP Statute.

In short, the inclusion of the statutory language, like utilization of the fee schedule itself, is entirely optional. While GEICO argues that it was their intent to only pay 80% of the charges submitted, GEICO, again as the master of its policy, had an obligation to spell out its intention and leave no reasonable interpretation to the contrary. This Court cannot rescue GEICO from its own contract language. *Barakat v. Broward Cty. Hous. Auth.*, 771 So.2d 1193, 1195 (Fla. 4th DCA 2000) (finding "[i]t is never the role of a…court to rewrite a contract to make it more reasonable for one of the parties or to relieve a party from what turns out to be a bad bargain").

D. Rules of Contract Interpretation Support Plaintiff's Not Defendant's Interpretation.

Fourth, GEICO is wrong that its failure to expressly waive a 20% coinsurance limitation on insureds in the GEICO Policy [D.E. 46 at 16], negates its express language to the contrary. The underlying legal maxim GEICO seeks to invoke is "casus omissus pro omisso habendus est or 'nothing is to be added to what the text states or reasonably implies.'" *Villanueva v. State*, 200 So. 3d 47, 52 (Fla. 2016) (citing among others, Scalia & Garner at 93).

But this is *not* a controversy about adding text to express terms of a contract or statute. Rather it *is* a controversy about what an insurance contract states expressly and honoring the text as written.

Again, as quoted above, GEICO specifically and expressly states, "a charge submitted by a provider, for an amount less than the amount allowed above ***shall be paid in the amount of the charge submitted.*"** (emphasis added). A more appropriate interpretative maxim that can be applied here is *expressio unius est exclusio alterius*—defined in a contract context to mean "the expression in a contract of one or more things of a class implies the exclusion of all not expressed, even though all would have been implied had none been expressed." *S. Coast Corp. v. Sinclair Ref. Co.*, 181 F.2d 960, 961 (5th Cir. 1950). Considering this maxim and even "casus omissus…" GEICO tries to invoke, GEICO has it backwards: GEICO's specific unqualified statement that it shall pay the amount of charges submitted when they are less than fee schedule amounts, excludes reading other language into the GEICO Policy that would qualify or contradict it. Had GEICO intended to qualify it, GEICO would have expressly said so in the policy text. It didn't. The Court should not accept GEICO's invitation to read text into the policy that is not there.

III. Even if the GEICO Policy is Ambiguous, Plaintiff's Interpretation Prevails.

Finally, assuming for the sake of argument, that GEICO's interpretation is reasonable (which it isn't), Plaintiff's interpretation should still be accepted and prevail. If the language in an insurance policy is susceptible to more than one reasonable interpretation, then the language is ambiguous and is to be construed strictly against the insurer and in favor of insured. *Washington Nat. Ins. Corp. v. Ruderman*, 117 So. 3d 943, 948 (Fla. 2013).

This principle is illustrated in the PIP context in *Infinity Auto. Ins. Co. v. Sunshine Rehab & Medical, Inc. (a/a/o Osvaldo Borras)*, 22 Fla. L. Weekly Supp. 675a (11th Cir. Ap. 2015), *cert. denied*, 2015 WL 5834285 (Fla. 3d DCA 2015), which is on point. The insurer Infinity issued a policy that limited payment to the "schedule of maximum charges, rather than 80% of the schedule of maximum charges." Much like GEICO, Infinity argued that it was only required to pay 80% of

the charge rather than 100%. The court disagreed, found the language ambiguous, and construed the language against Infinity.

IV. Conclusion

There are no material facts in dispute. The GEICO Policy and relevant facts concerning its reason for reducing reimbursement to Plaintiff are established. The Court should rule as a matter of law that the plain text in the GEICO Policy cannot be clearer: if a provider bills less than 200% of Medicare, GEICO "shall [pay it] in the amount submitted." Even if GEICO's interpretation were reasonable, under Florida law the Court should adopt Plaintiff's interpretation. Plaintiff's motion for partial summary judgment on the proper interpretation of the GEICO Policy should thus be granted unequivocally in Plaintiff's favor.

Dated: May 12, 2017

Respectfully submitted,

/s/ Todd S. Payne
Todd S. Payne, Esq. (FBN 834520)
E-mail:tpayne@zpllp.com
Edward H. Zebersky, Esq. (FBN 908370)
E-mail: ezebersky@zpllp.com
Michael T. Lewenz, Esq. (FBN 111604)
E-mail: mlewenz@zpllp.com
ZEBERSKY PAYNE, LLP
110 Southeast 6th Street, Suite 2150
Fort Lauderdale, FL 33301
Telephone: (954) 989-6333
Facsimile: (954) 989-7781

Steven R. Jaffe, Esq. (FBN 390770)
E-mail: steve@pathtojustice.com
Mark S. Fistos, Esq. (FBN 909191)
E-mail: mark@pathtojustice.com
FARMER, JAFFE, WEISSING,
EDWARDS, FISTOS & LEHRMAN, P.L.
425 North Andrews Avenue, Suite 2
Fort Lauderdale, FL 33301
Telephone: (954) 524-2820
Facsimile: (954) 524-2822
Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on May 12, 2017, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system which will automatically send notification to all attorneys of record

/s/ Todd S. Payne
Todd S. Payne