

IN THE COUNTY COURT OF THE 17<sup>th</sup>  
JUDICIAL CIRCUIT IN AND FOR  
BROWARD COUNTY, FLORIDA

TED BERGER, D.C., P.A., INC. a/a/o Giselle  
Victor,

Case No: 10 04828 COCE 54

Plaintiff,

vs.

GEICO GENERAL INSURANCE COMPANY,

Defendant

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**FINAL ORDER**

THIS CAUSE having come before the Court for hearing on January 27, 2011 on Plaintiff's Motion for Partial Summary Judgment on Defendant's 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> Affirmative Defenses, and Defendant's Cross Motion for Final Summary Judgment, and the Court having made a thorough review of the matters filed on record, Plaintiff's Motion, Defendant's Cross Motion, heard arguments of counsel, and being otherwise fully advised in the Premises, it is hereupon

ORDERED AND ADJUDGED:

*Background*

The Plaintiff, Ted Berger, D.C., P.A. brought an action on behalf of GEICO's insured, Giselle Victor, seeking to recover Personal Injury Protection (PIP) benefits.

Plaintiff's Complaint alleges it has standing to bring forth its suit based on an assignment of benefits executed by Giselle Victor.

Plaintiff moved forward on Motions for Partial Summary Judgment on Defendant's 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> affirmative defenses. Defendant filed its Response to Plaintiff's Motions for Partial Summary Judgment on Defendant's 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> Affirmative Defenses and Cross Motion for Final Summary Judgment.

Defendant's First Affirmative Defense alleges that Plaintiff failed to comply with a statutory condition precedent to bringing this suit, as mandated by Section 627.736 (10) Florida Statutes (2008).

Plaintiff argued that it substantially complied with the pre-suit demand requirements of F.S. 627.736 (10), and that Defendant failed to notify Plaintiff of any defects in the DEMAND, and as a result Defendant has waived any defense on this issue.

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Exhibit 9

### *Undisputed Findings of Fact*

The facts material to Defendant's Cross Motion for Final Summary Judgment are undisputed and established by the pleadings and discovery on record, and the material facts are set forth below.

Defendant issued a policy of insurance to GISELLE VICTOR, which provides PIP benefits with limits of \$10,000.00. The policy also had an applicable \$1,000.00 deductible and provided for coverage at 80% with the insured having a 20% co-payment, once the deductible is met, and no additional Med Pay coverage.

Plaintiff rendered medical treatment and/or services to GISELLE VICTOR from July 10, 2009 through November 4, 2009 for injuries she allegedly sustained in a July 7, 2009 motor vehicle accident.

On February 8, 2010 Plaintiff mailed its "Demand Letter Pursuant to Florida Statutes 627.736 (10)" to Defendant, which Defendant received February 11, 2010. The DEMAND stated:

"Amount Due - \$9,275.00 Billed - (\$4,293.94) Paid = \$4,891.06 Outstanding Balance."

This DEMAND had a "Transaction Journal" attached, which included all dates of service and charges. The DEMAND included no other language or specificity as to what amount of payment Defendant was required pay in order to avoid litigation, but included hand written *asterisks* next to each entry on the Transaction Journal for dates of service October 7, 21 and 28, 2009. The items with the hand written asterisks totaled \$1,190.00.

Defendant timely responded to Plaintiff's DEMAND stating that dates of service 07/07/09 and 07/20/09 were applied to the patient's deductible; that all other aforementioned dates of service were paid at 80% of the allowable amount per F.S. 627.736; that additional payment was due for dates of service 07/22/09 - 07/27/09, and that checks were issued and sent separately for \$304.80 amount due under PIP, \$14.43 interest due, \$31.92 penalty amount and \$5.88 mailing amount. Defendant also provided Plaintiff with a PIP payout log and explanations of benefits in response to the DEMAND.

Plaintiff cashed, honored or otherwise endorsed the payments issued in response to the DEMAND, and made no subsequent demand for payment. Plaintiff filed suit for breach of contract damages alleging in its Second Amended Complaint that damages are owed in the amount of \$1,190.00 for October 7, 21 and 28, 2009 dates of service.

### *Findings of Law*

The Court hereby adopts the foregoing findings of fact to the extent they encompass conclusions of law or mixed findings of fact and conclusions of law.

Plaintiff argued its DEMAND substantially complied with F.S. § 627.736 (10) because the attached Transaction Journal was an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due, and further that the hand written asterisks on the Transaction Journal next to the three dates of service at issue in this suit placed Defendant on notice as to what exact amount was due.

This argument is misplaced. Plaintiff's DEMAND specifically provided a formula or calculation of the "amount due," which was \$4,891.06. Yet, the charges with hand written asterisks on the Transaction Journal totaled only \$1,190.00, not the \$4,891.06 "amount due". Plaintiff admitted that two of the three dates of service with hand written asterisks on the Transaction Journal were never billed to Defendant, and that the charges for the October 21, 2009 date of service were listed twice, although the services were only provided once. Finally, Plaintiff testified that it accepted the Medicare Fee Schedule reimbursement amount for PIP benefits (Fla. Stat. § 627.736 (5) (a) 2 f); however, its DEMAND sought payment at 100% of the total amount billed, despite the overcharges, applicable deductible, 80% coverage, and fee schedule reimbursement.

It is well settled law that an insurance company is not required to pay more than the amount it contractually agreed to pay. See, *SIMON V. PROGRESSIVE EXPRESS INS. CO.*, 904 So 2d 449 (Fla. 4th DCA 2005); see also *B&D CHIROPRACTIC CENTER (A/A/O LINA YEPES) V. PROGRESSIVE EXPRESS INS. CO.* 15 Fla. Law Weekly Supp. 334a (17th Jud. Cir. Appellate Nov. 6, 2007); *MILLENNIUM DIAGNOSTIC IMAGING CENTER, INC. A/A/O ALFONSO TABOADA V. PROGRESSIVE EXPRESS INS. CO.*, 987 So 2d 755 (Fla. 3d DCA 2008); and *PROGRESSIVE AMERICAN INS. CO. V. STAND-UP MRI OF ORLANDO (A/A/O ISAAC EUSEBIO)*, 990 So 2d. 3 (Fla. 5th DCA 2008). Plaintiff's DEMAND included charges that were double billed and never billed to Defendant. Further, Plaintiff accepted payment at the Medicare Fee schedule. Therefore, the DEMAND included charges which Defendant was not required to pay pursuant to the contract of insurance and F.S. § 627.736.

Florida's PIP statute is very specific as to what is required of both sides with respect to the demand letter. See *STATE FARM FIRE AND CASUALTY CO. V. MRI ASSOCIATES OF AMERICA, LLC A/A/O EBBA REGISTER*, 17 Fla. L. Weekly Supp. 745a (15<sup>th</sup> Judicial Circuit Appellate-Civil May 4, 2010) (The language in the statute is unambiguous and places the burden on the medical care provider/claimant to "leave no question as to what amounts are being sought by the notice.") Citing *PHYSICAL THERAPY GROUP, LLC V. MERCURY INSURANCE CO. OF FLORIDA*, 13 Fla. L. Weekly Supp. 889c (Fla. 11<sup>th</sup> Cty. Ct. June 2, 2006). (However, an insurer is not properly placed on notice if the wrong amount is stated in the demand letter.) See *id.*; see also *WIDE OPEN MRI V. MERCURY INSURANCE GROUP*, 16 Fla. L. Weekly Supp. 513b (Fla. 17<sup>th</sup> Cir. Ct. March 13, 2009); *SUN COAST HEALTH CARE CENTER #1, INC. (PAMELA SEGAL) v. PROGRESSIVE EXPRESS INSURANCE COMPANY*, 12 Fla. L. Weekly Supp. 803c (County Court, 17th Judicial Circuit in and for Broward County, May 3, 2005) (If a medical provider is going to use a patient ledger as an itemized statement they must clearly mark the services in a manner that the Insurer will be able to determine which services were paid, which services were reduced, and if reduced, by how much. Legislative intent would be frustrated if a medical care provider was not required to provide an insurer with the statutorily mandated specificity in their itemized statement).

Defendant also relied on the following: *TAMPA BAY IMAGING LLC., A/A/O CATHY ROSS, V. ESURANCE INSURANCE COMPANY*, Fla. L. Weekly Supp. 17 1033b (13th Cir., County Court, December 2, 2009) (Defendant would *never owe the amount specified in the demand letter*. Consequently, to allow the Plaintiff, Tampa Bay Imaging, LLC, to proceed on a defective or statutorily deficient presuit demand letter would essentially circumvent the legislative purpose of the presuit demand letter provisions of the Florida Motor Vehicle No-Fault law), *TAMPA BAY IMAGING, LLC A/A/O RODNEY DEVORE V. ESURANCE*

*INSURANCE COMPANY*, 17 Fla. L. Weekly Supp. 234a (13th Cir., County Court, June 11, 2009) (the demand provisions of the PIP statute clearly sets forth a number of items, which need to be included in the notice prescribed by this section. "In fact, this section uses the words "shall state with specificity" and "itemized statement specifying each exact amount." Clearly, language such as this is unambiguous and places the burden upon the Claimant. . . to leave no question as to what amounts are being sought by the notice). *Citing FOUNTAIN IMAGING OF WEST PALM BEACH, LLC V. PROGRESSIVE EXPRESS INSURANCE CO.*, 14 Fla. L. Weekly Supp. 614a (15th Cir. Appellate-Civil 2007) (insurer filed motion for summary judgment, claiming presuit demand letter defective because it failed to state "exact amount" owed; summary judgment granted as provider's claim and demand letter sought amounts that, as matter of law, were not reasonable. . . It is the opinion of this Court that the Plaintiff's presuit demand that requests the Defendant to pay an amount in excess of the amount they are required to pay under the Florida No-Fault, and Medicare Part B fee schedules is invalid). The Court finds these holdings persuasive in the instant matter.

Plaintiff failed to strictly adhere to the Demand Letter Requirements as required under Florida Statute, §627.736(10) (2008). Plaintiff's DEMAND and attached transaction journal was vague, confusing, misleading, inaccurate and failed to accurately specify the amount billed or amount due, failed to provide an itemized statement that specified each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. The attached transaction journal included duplicate entries for at least one date of service, included at least two dates of service that were never billed to Defendant, demanded 100% of the amount billed, failed to account for the applicable deductible and co-payment, or that Plaintiff accepted the Medicare Part B fee schedule reimbursement. The demand letter did not allow the Defendant to ascertain what amounts Plaintiff was alleging were due and owing and most importantly, what amount Defendant needed to pay in order to avoid litigation.

Next, Plaintiff argued that Defendant waived any defenses to Plaintiff's failure to comply with F.S. § 627.736 (10). Plaintiff relied on *CHIRO-MEDICAL REHABILITATION OF ORLANDO, INC. V. PROGRESSIVE EXPRESS INSURANCE CO*, 12 Fla. L. Weekly Supp. 162b (2004); *RAPID REHABILITATION, INC. A/A/O VERONA GRAHAM V. UNITED AUTO*, 14 Fla. L. Weekly Supp. 108a (2006) (citing to *OPEN MRI OF MIAMI, LTD. A/A/O. JOSEPH VINCENT V. PROGRESSIVE EXPRESS INSURANCE CO.* (Fla. 11<sup>th</sup> Cir. Ct. Dec. 25, 2005)), and *GLEN BERGER, D.C., P.A. A/A/O MARIE JEAN V. UNITED AUTO*, 16 Fla. L. Weekly Supp. 2676 (17<sup>th</sup> Circuit, January 6, 2009).

In *Chiro-Medical*, the Court held that, "As a matter of public policy it is of paramount importance that the Demand Letter requirements of Fla. Stat. 627.736(11) [amended in 2008 as Fla. Stat. 627.736 (10)] are strictly adhered to. Allowing medical care providers to loosely adhere to the Demand Letter requirements would unquestionably cause the price of automobile insurance to increase because of the additional costs that would result from litigation that could have been avoided by the insurer and the provider if the insurer would have been given a fair representation of the true amount at issue. It is unfortunate reality that in the processing of medical claims mistakes will at times be made by both the insurer and the medical care provider. Thus, to mitigate the negative consequences of such inevitable mistakes, legislatively prescribed safeguards must be strictly adhered to for the benefit of the insured, medical care provider, and the insurer." While the Court agrees with this holding; it

serves no basis or support for Plaintiff's case and further supports Defendant's first affirmative defense.

This Court finds *Rapid Rehabilitation* and *Glen Berger* to be factually distinguishable from the present matter. In both of those cases, the insurer paid nothing on the initial claim submitted by the providers, did not respond to the demand letters, and never provided those medical providers with any explanations of benefits or PIP payout logs. Simply put, they ignored the bills and the demand. The Court found that under those factual circumstances, the insurer is in the best position to know what amount is outstanding and that the Plaintiffs substantially complied with the demand requirements by attaching all of the bills to the demands. In the present matter, however, GEICO paid Plaintiff's bills, provided explanations of benefits and a PIP payout log and issued payment in response to the demand, which included interest, penalty, and postage. GEICO did not ignore the demand like the insurers in *Rapid Rehab* and *Glenn Berger*, only to take issue with the sufficiency of the demand long after suit was filed. To the contrary, GEICO attempted to extinguish any potential litigation by issuing payment and providing the requested explanations of benefits and PIP payout log. This Court finds that GEICO's response to the DEMAND, issuance of payment and providing the explanations of benefits and PIP payout log did not act as a waiver to the defense of the DEMAND being legally insufficient. Furthermore, Defendant raised this affirmative defense in its initial Answer.

#### *Final Judgment*

IT IS HEREBY ORDERED AND ADJUGED that Dr. Ted Berger, D.C., P.A.'s Motion for Partial Summary Judgment on Defendant's 1<sup>st</sup> Affirmative Defense is denied. GEICO General Insurance Company's Motion for Final Summary Judgment is hereby granted, and Final Judgment is hereby entered on behalf of Defendant, GEICO General Insurance Company. Defendant shall go henceforth without day. This Court retains jurisdiction for the purpose of determining any Motion to Tax Fees and Costs by Defendant.

Because the Court enters Final Judgment on Defendant's 1<sup>st</sup> affirmative defense, it is not necessary to address the cross motions for summary judgment on Defendant's 2<sup>nd</sup> or 3<sup>rd</sup> affirmative defenses.

DONE AND ORDERED in Chambers, at Broward County Courthouse, 201 S.E. 6th Street, Fort Lauderdale, FL 33301 this 28 day of February, 2011. LISA TRACHMAN



HON. LISA TRACHMAN  
COUNTY COURT JUDGE

FEB 28 2011

A TRUE COPY

Copies furnished to:  
DREW A. STOLLER, ESQ.  
GREGG PESSIN, ESQ.