DISTRICT COURT OF APPEAL OF FLORIDA
SECOND DISTRICT

PROGRESSIVE AMERICAN INSURANCE COMPANY,

Appellant,

v.

BACK ON TRACK, LLC, a/a/o Ophelia Bailey,

Appellee.

No. 2D21-541

July 1, 2022

Appeal from the Circuit Court for Hillsborough County; James S. Moody, Judge.

Kenneth P. Hazouri of deBeaubien, Simmons, Knight, Mantzaris & Neal, LLP, Orlando, for Appellant.

Matthew Emanuel and Alexander D. Licznerski of Landau & Associates, P.A., Sunrise, for Appellee.

LABRIT, Judge.

Progressive American Insurance Company (Progressive) appeals a final summary judgment in favor of Back on Track, LLC

(BOT), a medical provider to which Progressive's insured, Ophelia Bailey, assigned her personal injury protection (PIP) benefits. The trial court determined that Progressive could not pay BOT 80 percent of the amounts BOT charged, and instead was required to pay either 100 percent of BOT's charges or 80 percent of the amount allowed under the statutory schedule of maximum charges identified in section 627.736(5)(a)1, Florida Statutes (2014).

For the reasons explained below, we reverse and remand for entry of judgment in favor of Progressive. We also certify conflict with *Geico Indemnity Co. v. Affinity Healthcare Center at Waterford Lakes, PL*, 336 So. 3d 404 (Fla. 5th DCA 2022); *Hands On Chiropractic PL v. GEICO General Insurance Co.*, 327 So. 3d 439 (Fla. 5th DCA 2021); and *Geico Indemnity Co. v. Muransky Chiropractic P.A.*, 323 So. 3d 742 (Fla. 4th DCA 2021), to the extent those decisions

> hold that when an insurer chooses to reimburse according to scheduled rates, it must pay 80 percent of 200 percent of the statutorily adopted applicable fee schedule. There is nothing in the [PIP] statutory scheme that permits a PIP insurer to limit reimbursements to 80 percent of the billed amount.

Hands On, 327 So. 3d at 440 (footnote omitted).

I.

The facts are undisputed. Ms. Bailey was injured in an automobile accident and was treated by BOT, which directly billed Progressive for its treatment of Ms. Bailey between May and July 2015. In relevant part, Progressive's policy states that it will pay "medical benefits," which are defined as "80 percent of all reasonable expenses incurred for medically necessary medical . . . services." The policy also provides that Progressive

> will determine to be unreasonable any charges incurred that exceed the maximum charges set forth in Section 627.736 (5)(a)(2) (a through f) of the Florida Motor Vehicle No-Fault Law, as amended. Pursuant to Florida law, [Progressive] will limit reimbursement to, and pay no more than, 80 percent of the following schedule of maximum charges:
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> . . . .
>
> f. for all other medical services, supplies and care, 200 percent of the allowable amount under the participating physicians fee schedule of Medicare Part B . . . .

BOT submitted some charges that were less than the allowable amount under the statutory schedule of maximum charges, and Progressive reimbursed BOT at 80 percent of the face amount of those charges. Other charges BOT submitted exceeded 80 percent of the allowable amount under the schedule of maximum charges,

and Progressive limited reimbursement for those charges in accordance with section 627.736(5)(a)1.

In July 2019, BOT sued Progressive, alleging that Progressive breached the PIP policy because it "denied coverage for, withheld or reduced the medical bill(s) that were submitted by [BOT] for date(s) of service May 15, 2015[,] through July 21, 2015[,] and/or misapplied the application of the deductible." BOT attached and incorporated to the complaint a copy of its "patient bill," which is an eight-page list of each individual service provided to Ms. Bailey during the operative timeframe, together with corresponding charges and payments BOT received for each service. Progressive answered the complaint and asserted several defenses.

Progressive moved for summary judgment, arguing that it had paid all of BOT's charges consistent with the requirements of the PIP statute and Progressive's PIP policy. More specifically, Progressive argued that (1) its PIP policy provided legally sufficient notice that Progressive would limit reimbursements pursuant to the

statutory schedule of maximum charges[1] and (2) it properly applied the Multiple Procedure Payment Reduction (MPPR)[2] to some of BOT's charges as authorized by subsection 627.736(5)(a)1 and 3. In support of that motion, Progressive filed the affidavit of its litigation adjuster who attested that BOT billed a total of $10,612 for services it rendered to Ms. Bailey and that Progressive paid BOT $7,239 after applying the $1,000 deductible.

Several months later, BOT filed three separate motions for summary judgment directed to three distinct categories of charges encompassed by its complaint. In the first motion, BOT conceded that Progressive's policy and the PIP statute authorized Progressive to use the fee schedule limitations and apply the MPPR, but BOT argued that Progressive "incorrectly" applied the MPPR to certain charges. In the second motion, BOT argued that Progressive underpaid a hydrotherapy charge. In the third motion, BOT argued

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[1] An insurer may use the statutory schedule of maximum charges to limit provider reimbursement only if it has provided policy-based notice that it will do so. *See* § 627.736(5)(a)5.

[2] The MPPR is a payment limitation that Medicare applies to certain codes reimbursable under the Medicare Part B participating physician fee schedule.

that Progressive underpaid charges for seven different procedure codes by paying 80 percent of the charge submitted, rather than the full amount of the bill. In that motion, BOT framed the issue as whether an insurer that

> elected to pay the amount of the charge submitted when less than the allowable amount under the schedule of maximum charges (commonly referred to as a "Billed Amount" or "BA" payment) is obligated to pay the "amount of the charge submitted" or 80% of the amount of the charge submitted.

In December 2020, Progressive filed an amended motion for summary judgment in which it argued that it properly reimbursed BOT for the "Billed Amount" charges by paying 80 percent of the amount BOT billed for such charges. The trial court convened a hearing on January 21, 2021. At the outset, both parties' counsel agreed that the material facts were undisputed; BOT's counsel also expressly confirmed that "MPPR is not at issue any longer" and that he was "not proceeding" on the hydrotherapy charge claim. In short, the parties agreed that the sole issue for resolution was the legal question of whether Progressive was required to pay BOT's "Billed Amount" charges at either 100 percent of the amount billed

or at 80 percent of the amounts prescribed by the applicable statutory schedule of maximum charges.

At the end of the hearing, the trial court announced its determination that neither the PIP statute nor Progressive's PIP policy authorizes Progressive to pay 80 percent of the amount billed where that amount is less than the amount allowed under the statutory schedule of maximum charges. The court entered an order denying Progressive's motion and granting BOT's motion; the order states that the ruling was based on *Geico Indemnity Co. v. Accident & Injury Clinic, Inc. ex rel. Irizarry*, 290 So. 3d 980 (Fla. 5th DCA 2019), and reflects the court's conclusion that Progressive "was required to pay 80% of the applicable fee schedule amount for [BOT's] charges . . . or to pay the charge at 100% of the full amount billed for those charges billed below 80% of the schedule of maximum charges." Several days later, the court entered final judgment in favor of BOT, awarding BOT $999 as damages for unpaid PIP benefits together with pre- and postjudgment interest on that amount. Progressive timely appeals.

II.

We review a final summary judgment de novo. *See State Farm Mut. Auto. Ins. Co. v. MRI Assocs. of Tampa, Inc.* (*MRI I*), 252 So. 3d 773, 776 (Fla. 2d DCA 2018), *approved by MRI Assocs. of Tampa, Inc. v. State Farm Mut. Auto. Ins. Co.* (*MRI II*), 334 So. 3d 577 (Fla. 2021); *see also Allstate Ins. Co. v. Orthopedic Specialists* (*Orthopedic Specialists II*), 212 So. 3d 973, 975 (Fla. 2017) ("Because the question presented requires this Court to interpret provisions of the Florida Motor Vehicle No-Fault Law—specifically, the PIP statute—as well as to interpret the insurance policy, our standard of review is de novo." (quoting *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*, 141 So. 3d 147, 152 (Fla. 2013))).

We first review the fundamental "coverage mandate" that the PIP statute imposes on insurers. Section 627.736(1)(a) requires PIP insurers to provide coverage for "[e]ighty percent of all reasonable expenses for medically necessary medical . . . services." This "reasonable medical expenses coverage mandate" is the "heart of the PIP statute's coverage requirements." *Orthopedic Specialists II*, 212 So. 3d at 976.

In the fifty years "[s]ince its inception, the PIP statute has been the playing field where providers and insurers battle over the meaning of its language." *Orthopedic Specialists v. Allstate Ins. Co.* (*Orthopedic Specialists I*), 177 So. 3d 19, 30 (Fla. 4th DCA 2015) (May, J., dissenting), *quashed by Orthopedic Specialists II*, 212 So. 3d at 974. Since the late 1990s, the provider/insurer litigation battles have focused principally on whether insurers' reimbursements to medical providers comport with the coverage mandate. In keeping with the purpose of the PIP statute—which the supreme court has said is to "provide swift and virtually automatic payment so that the injured insured may get on with his [or her] life without undue financial interruption," *Virtual Imaging*, 141 So. 3d at 153[3] (alteration in original)—the legislature has reacted by amending the statutory provisions regarding provider reimbursement and has significantly amended those provisions at

[3] The legislature has expressed the purpose of the No-Fault Law in somewhat different terms: "to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault, and to require motor vehicle insurance securing such benefits . . . and, with respect to motor vehicle accidents, a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience." § 627.731, Fla. Stat. (2014).

least four times in the last twenty years. These amendments invariably are followed by more litigation and revised PIP policy forms, so the "battle rages on." *See Orthopedic Specialists I*, 177 So. 3d at 30 (May, J., dissenting).

Much of the battle for the last ten years or so has been over insurers' use of the fee schedule limitations, which the legislature implemented in 2008. *See MRI II*, 334 So. 3d at 579 (noting that in the last decade, the court has considered three cases involving a provider's challenge to "an insurer's use of the PIP statutory schedule of maximum charges"), *cert. denied*, 142 S. Ct. 1677 (2022). This case presents a permutation of the challenge the provider raised in *MRI II*. For the reasons we explain below, the reasoning our supreme court articulated in *MRI II* controls the outcome of this case.

III.

Progressive's argument is simple: it contends that it satisfied the statutory coverage mandate to pay 80 percent of Ms. Bailey's reasonable medical expenses by accepting BOT's charges at face value and paying 80 percent of those charges. BOT argues that because Progressive's PIP policy incorporates the fee schedule

limitations, Progressive must pay **all** charges at the amounts prescribed in the applicable schedule, even if the amount the provider has charged is lower than the amount allowed under the applicable schedule. To explain why BOT's argument is flawed and why the trial court erred by accepting it, we examine *Irizarry* and its progeny with the benefit of the supreme court's analysis in *MRI II*.

In *Irizarry*, the Fifth District granted Geico's petition for second-tier certiorari and quashed a circuit court appellate decision affirming a county court judgment in favor of a medical provider. 290 So. 3d at 981–82. The county court had concluded that Geico's PIP policy required it to "pay the full amount of the charge submitted for those charges that are submitted in an amount which is less than 200% of the participating physicians fee schedule of Medicare Part B." *Id.* at 982. Geico's policy stated that it would pay PIP benefits in accordance with the fee schedule limitations, and also provided that "[a] charge submitted by a provider, for an amount less than the amount allowed [under the fee schedules]

shall be paid in the amount of the charge submitted." *Id.* (emphasis omitted).[4]

Geico appealed to the circuit court, arguing that neither its PIP policy nor the PIP statute required it to pay 100 percent of the amount billed where the amount was less than the amount allowed under the statutory schedule of maximum charges. *Id.* The circuit court affirmed the county court decision, reasoning that subsection 627.736(5)(a)5 required Geico to pay the bill in full. *Id.* at 982–83.

The Fifth District framed the question for review as follows: "Does the plain language of the PIP statute preclude an insurer from limiting its reimbursement to 80% of the total billed amount when the amount billed is less than the statutory fee schedule?" *Id.* at 983. The court then reviewed subsection (5)(a) of the PIP statute, noting that subparagraph (5)(a)1 authorizes insurers to limit reimbursements to 80 percent of the schedule of maximum charges,

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[4] Progressive's policy contains no similar provision. And unlike Geico's policy, Progressive's policy doesn't state that it will pay medical benefits "pursuant to the" statutory schedule of maximum charges. *Irizarry*, 290 So. 3d at 982. Progressive's policy states that it "will determine to be unreasonable any charges incurred that exceed the maximum charges set forth in" the statutory schedule.

and next examined subparagraph (5)(a)5, which provides that "[i]f a provider submits a charge for an amount less than the amount allowed under subparagraph 1[], the insurer may pay the amount of the charge submitted." *Id.* Concluding that " 'the amount allowed under subparagraph 1' necessarily encompasses 80% of the applicable fee schedule option," the court held that "if the billed amount *is less than 80% of the fee schedule* (the required amount an insurer must pay), the insurer **may** opt to pay the lower amount in full." *Id.* at 984 (bold emphasis added). It quashed the circuit court appellate decision and remanded the case for further proceedings. *Id.*

Eighteen months later, the Fourth District considered Geico's appeal from an order determining that it was required to pay the full amount of a bill where the provider had billed "an amount less than 80% of the schedule of maximum charges." *Muransky*, 323 So. 3d at 744–45. The court affirmed. *Id.* at 744. Although it cited *Irizarry* for the proposition that "under the PIP statute, if the billed amounts are less than 80% of the fee schedule, the insurer may pay the billed amounts in full or pay the 80% reimbursement rate of maximum charges," *id.* at 747, it appears that the ultimate holding

was based on Geico's policy language, which was identical to that featured in *Irizarry*, *see id.* at 748–49. In its conclusion, the court stated that it was affirming "because the policy's plain language indicates that Geico is obligated to pay 100% of Provider's billed amounts." *Id.* at 749. In a footnote, the court explained that its conclusion was limited to the circumstance where a provider charged less than 80 percent of 200 percent of the applicable Medicare fee schedule amount; the court made "no determination as to what the result would have been" had the provider charged an amount "under the 200% of the statutory fee schedule but above the 80% reimbursement rate." *Id.* at 749 n.2.[5]

A few months later, the Fifth District issued its decision in *Hands On*. *Hands On* and *Irizarry* featured similar background: the provider billed Geico more than 80 percent of 200 percent of the

[5] Some of BOT's charges were less than 80 percent of 200 percent of the applicable fee schedule amount and some were less than 200 percent of the applicable fee schedule amount but more than 80 percent of the allowable amount pursuant to the applicable fee schedule. Our conclusion that Progressive was entitled to reimburse BOT's charges at 80 percent of the amount that BOT billed and that such reimbursement was reasonable as a matter of law obviates the need to address the dichotomy identified in footnote 2 of *Muransky*.

applicable Medicare fee schedule, but less than 200 percent of the applicable schedule; Geico paid 80 percent of the total bill; the county court ruled that Geico was required to pay the full billed amount; and Geico appealed to the circuit court. *Hands On*, 327 So. 3d at 441. In the *Hands On* appeal, Geico argued—and the circuit court agreed—that Geico should be "allowed to apply its 20 percent coinsurance charge against all PIP medical reimbursements." *Id.* Hands On petitioned for second-tier certiorari review. *Id.*

The Fifth District concluded that "the circuit court departed from the essential requirements of law when it ruled that Geico could limit payments to 80 percent of the billed amount submitted by Hands On, as there is no such provision in the controlling statute." *Id.* Instead of quashing the order on review, the court exercised its appellate jurisdiction to affirm in part and remand to the county court "for calculation and entry of a final judgment ordering Geico to reimburse Hands On at the rate of 80 percent of 200 percent of the applicable fee schedule." *Id.*

In determining that Geico's payment of 80 percent of the billed amount was an "Unauthorized Hybrid Payment", the court explained that

> nothing in the applicable statute or Geico's policy . . . allows it to pay 80 percent of the billed amount. It must either pay the amount allowed based on the applicable fee schedule (80 percent of 200 percent) or, if the billed amount is less than the amount allowed, it is to be paid in full. Therefore, Geico's hybrid payment to Hands On at 80 percent of the billed amount is impermissible.

Id. at 442–43. In so concluding, the court reasoned that subsection 627.736(5)(a)5 was "inapplicable" because Hands On's charge "was more than 80 percent of the 200 percent fee schedule" and "the 'amount allowed under subparagraph 1[]' refers to 80 percent of the 200 percent of the applicable fee schedule." *Id.* at 442–43.

The most recent decision in a PIP "billed amount" case is the Fifth District's opinion in *Affinity*. There, the court applied *Hands On* to reach this conclusion:

> [T]he trial court erred in requiring Geico to pay 100% of Affinity's billed amount where the billed amount was more than 80% of 200% of the applicable fee schedule. Although the trial court properly rejected Geico's argument that it was only required to pay 80% of the billed amount, it should have ordered Geico to pay 80% of 200% of the applicable fee schedule.

Affinity, 336 So. 3d at 406.

Summarizing, these cases establish that a PIP insurer whose policy includes a notice that it may use the statutory schedule of maximum charges to determine provider reimbursements must (1) pay 100 percent of the amount billed if a provider charges less than 80 percent of the amount allowed under the schedule of maximum charges and (2) pay 80 percent of the allowable amount under the applicable schedule of maximum charges for charges that exceed 80 percent of 100 percent of the allowable amount calculated under the applicable schedule of maximum charges.[6] As we next explain, we disagree with this proposition.

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[6] *Hands On* suggests that **all** allowable amounts under the schedule of maximum charges are calculated at 80 percent of 200 percent of a Medicare fee schedule. *See Hands On*, 327 So. 3d at 440, 443, 444. This is incorrect. The allowable amounts of reimbursement for emergency transport and treatment by providers licensed under chapter 401 (subsection (5)(a)1.a), for nonemergent hospital inpatient and outpatient services (subsections (5)(a)1.d and (5)(a)1.e), and for "all other medical services, supplies, and care" (subsection (5)(a)1.f) are 80 percent of 200 percent of an identified Medicare fee schedule. But the allowable amount for emergency hospital services is 80 percent of "75 percent of the hospital's usual and customary charges" (subsection (5)(a)1.b), and pursuant to subsection (5)(a)1.c, the allowable amount for emergency services and care provided in a facility licensed under chapter 395 is 80 percent of "the usual and customary charges in the community." *See* § 627.736(5)(a)1.

IV.

It is perplexing that none of these cases analyzes or even mentions whether an insurer's payment of 80 percent of a provider's billed amount does—*or does not*—comply with the statutory mandate that a PIP insurer must provide coverage for 80 percent of reasonable medical expenses. After all, the "reasonable medical expenses coverage mandate" is the "heart of the PIP statute's coverage requirements." *Orthopedic Specialists II*, 212 So. 3d at 976. Which is to say that a determination of whether a particular payment is or is not reasonable should be a fundamental component in the resolution of **any** dispute over the amount of reimbursement a PIP insurer has paid to a medical provider.[7]

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[7] At least one federal court has relied upon *Irizarry* to conclude that "nothing in the [PIP statute]" allows an insurer to pay 80 percent of the amount billed where the charge is for less than the allowable amount under the fee schedule limitations. *Revival Chiropractic LLC v. Allstate Ins. Co.*, No. 6:19-cv-445-PGB-LRH, 2020 WL 2483583, at *5 (M.D. Fla. Mar. 5, 2020). Without explanation, the district court indicated that it was "unpersuaded" by the insurer's argument that its payment of 80 percent of the provider's charge satisfied the coverage mandate. *See id.* at *4. Subsequently—and during the pendency of this appeal—the Eleventh Circuit issued a nondispositive opinion certifying the issue to the Florida Supreme Court. *See Revival Chiropractic LLC ex rel. Padin v. Allstate Ins. Co.,* 21-10559, 2022 WL 1799759 (11th Cir. June 2, 2022).

Progressive argued in the trial court, and argues in this court, that by paying 80 percent of the amount BOT charged for its treatment of Ms. Bailey, it satisfied the reasonable medical expenses coverage mandate. BOT doesn't address whether Progressive's payment of 80 percent of BOT's charges satisfied the reasonable medical expenses coverage mandate. Predictably, BOT's argument for affirmance is that because Progressive's PIP policy states that Progressive will use the statutory fee schedules to determine provider reimbursements, Progressive must pay all of BOT's charges at the maximum amounts allowed under the statutory fee schedules except charges for less than 80 percent of the allowable amount, which BOT contends Progressive must pay at 100 percent. Reduced to simple terms, BOT's theory is that once a PIP insurer makes a "fee schedule election," the schedule of maximum charges becomes the **exclusive** payment methodology for **all** medical provider reimbursements.

The genesis of this theory is the supreme court's decision in *Virtual Imaging*. In that case, the supreme court considered whether—under the 2008 version of the PIP statute (in which the legislature implemented the schedule of maximum charges)—a PIP

insurer whose policy stated that it would reimburse 80 percent of reasonable medical expenses but did not reference the statutory fee schedules could limit reimbursements in accordance with the fee schedules. *See Virtual Imaging*, 141 So. 3d at 154. The court held that "a PIP insurer cannot take advantage of the Medicare fee schedules to limit reimbursements without notifying its insured by electing those fee schedules in its policy." *Id.* at 160.

The *Virtual Imaging* majority explained that, under the 2008 version of the PIP statute, "there are two methodologies" for determining reasonableness of a medical provider's charge: an insurer may consider the factors enumerated in 627.736(5)(a)1 *or* it may limit reimbursements in accordance with the statutory schedule of maximum charges as authorized by section 627.736(5)(a)2. *Id.* at 156–57. Describing the fee schedule limitations as a "permissive methodology," the court held that an insurer could only use the fee schedule methodology to limit provider reimbursements if its policy "clearly and unambiguously" elected to do so. *Id.* at 157–58 (quoting *Kingsway Amigo Ins. Co. v. Ocean Health, Inc.*, 63 So. 3d 63, 67 (Fla. 4th DCA 2011)). In so holding, the court approved the Fourth District's decision in

Kingsway, which opined that a PIP policy providing reimbursement for 80 percent of reasonable expenses would afford "greater coverage" than a policy that permitted use of the fee schedule limitations. *Kingsway,* 63 So. 3d at 66, 68; *see Virtual Imaging*, 141 So. 3d at 158.

The *Virtual Imaging* dissent disagreed and would have disapproved *Kingsway*. *See Virtual Imaging*, 141 So. 3d at 160 (Canady, J., dissenting). As the dissent explained, the majority's view "rests on the interpretive fallacy that sections 627.736(5)(a)1 and 627.736(5)(a)2, Florida Statutes (2008), respectively establish mutually exclusive payment methodologies." *Id.* The dissent further explained that "[n]othing in the statute suggests that an insurer must make a one-time election between" the two payment methodologies authorized by "section 627.736(5)(a)1 and section 627.736(5)(a)2." *Id.* at 161.

Some four years later, the supreme court issued its decision in *Orthopedic Specialists II*, which arose under the 2009 version of the PIP statute and involved a provider's challenge to the legal sufficiency of a PIP insurer's notice of its election to use the fee schedule limitations. *Orthopedic Specialists II*, 212 So. 3d at 974.

The court reaffirmed the *Virtual Imaging* majority's statement that "[t]here are two different methodologies for calculating reimbursements to satisfy the PIP statute's reasonable medical expenses coverage mandate." *Id.* at 976. The court explained that "[u]nder the first payment methodology . . . 'reasonableness is a fact-dependent inquiry determined by consideration of various factors' " enumerated in section 627.736(5)(a)1, while the "alternative" methodology prescribed by section 627.736(5)(a)2 permits insurers to limit reimbursements to "eighty percent of a schedule of maximum charges set forth in the PIP statute." *Id.*[8]

Against this backdrop, an argument developed that PIP insurers were required to "elect either the reasonable charge method of calculation . . . or the schedule of maximum charges method," but could not use both methods. *MRI I*, 252 So. 3d at

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[8] In 2012, the legislature substantially revised section 627.736(5), which previously had classified the "fact-dependent" reasonable charge "methodology" under subsection (5)(a)1 and the "fee schedule" methodology under subsection (5)(a)2. By virtue of the 2012 amendments, the factors for consideration in determining a reasonable reimbursement amount are set forth in subsection (5)(a) and the statutory schedule of maximum charges is provided as "a subsection of the reasonable charge calculation methodology." *See MRI I*, 252 So. 3d at 777–78.

775–76. The question presented in *MRI I* was whether State Farm could limit medical provider reimbursements in accord with the statutory schedule of maximum charges where its PIP policy incorporated the "fact-dependent" reasonableness factors of section 627.736(5)(a) **and** the fee schedule limitations set forth in section 627.736(5)(a)1. *Id.* at 778. The provider contended that State Farm could not "elect both calculation methods" and that by doing so, State Farm had created an "unlawful hybrid method" for calculating provider reimbursements. *Id.* at 775–76

This court rejected the provider's "unlawful hybrid" argument. *See id.* at 776. We first analyzed *Virtual Imaging* and *Orthopedic Specialists II* and noted that neither of those decisions "applies to policies created after the 2012 amendment to the PIP statute." *Id.* at 777. We then concluded that by virtue of the 2012 amendments to the PIP statute, "there are no longer two mutually exclusive methodologies for calculating" reasonable provider reimbursements. *Id.* at 778. And we certified the following question of great public importance:

> DOES THE 2013 PIP STATUTE AS AMENDED PERMIT AN INSURER TO CONDUCT A FACT-DEPENDENT CALCULATION OF REASONABLE CHARGES UNDER

> SECTION 627.736(5)(a) WHILE ALLOWING THE INSURER TO LIMIT ITS PAYMENT IN ACCORDANCE WITH THE SCHEDULE OF MAXIMUM CHARGES UNDER SECTION 627.736(5)(a)(1)?

Id. at 778–79.

In December 2021, while this appeal was pending, the supreme court issued its decision in *MRI II*. It rephrased the certified question as follows:

> Does section 627.736(5)(a), Florida Statutes (2013), preclude an insurer that elects to limit PIP reimbursements based on the schedule of maximum charges from also using the separate statutory factors for determining the reasonableness of charges?

MRI II, 334 So. 3d at 585. Answering this question in the negative, the court first stated that *Virtual Imaging* and *Orthopedic Specialists II* contained no "holding" that there "are mutually exclusive methods for determining the reasonableness of reimbursements." *Id.* at 583. However, the court explained that the "statutory text . . . contains provisions that were not applicable in those cases and that wholly undermine the notion that section 627.736(5) establishes mutually exclusive reimbursement methodologies." *Id.* at 583, 585.

The court concluded that the 2012 version of the statute[9] "supports the result reached" in *MRI I*. *Id.* at 584. Specifically, the court analyzed the following provision of subsection 627.736(5)(a)(5):

> [A]n 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.

Id. at 584 (emphasis omitted). The court reasoned that this provision "cannot be reconciled with the argument that an election to use the limitations of the schedule of maximum charges precludes an insurer's reliance on the other statutory factors for determining the reasonableness of reimbursements." *Id.* And it explained that

> [t]he permissive nature of the statutory notice language does not in any way signal that the insurer will be so constrained by such an election. On the contrary, the language signals that **the insurer is given an option that may be used in addition to other options that are authorized**. This notice language echoes the

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[9] *MRI I* arose under the 2013 version of the PIP statute. *See MRI I*, 252 So. 3d at 774. Because Progressive issued its policy to Ms. Bailey in 2014, the 2014 version of the statute applies. *See Hassen v. State Farm Mut. Auto. Ins. Co.*, 674 So. 2d 106, 108 (Fla. 1996). The pertinent provisions of the 2012 statute are identical to those in the 2013 and 2014 versions of the statute.

> underlying authorization to limit reimbursements under the schedule of maximum charges: "The insurer *may limit* reimbursement to 80 percent of the [listed] schedule of maximum charges." § 627.736(5)(a)1., Fla. Stat. (emphasis added). **Given the full context of these provisions, a reasonable reading of the statutory text requires that reimbursement *limitations* based on the schedule of maximum charges be understood**—as State Farm contends—**simply as an optional method of capping reimbursements rather than an exclusive method for determining reimbursement rates. By its very nature, a limitation based on a schedule of maximum charges establishes a ceiling but not a floor**.

Id. at 584–85 (second alteration in original) (bold emphasis added). In conclusion, the court "reject[ed] the argument that State Farm has used a prohibited hybrid-payment methodology" and it approved the result this court reached in *MRI I*. *Id.* at 585.

V.

Although the issue presented in *MRI II* differed from the issue we now consider, the reasoning of *MRI II* nonetheless guides our resolution of this case. The "unlawful hybrid" theory is a predicate of the Fifth District's *Hands On* decision, and it forms the basis for BOT's arguments here. BOT agrees that Progressive is entitled to use the statutory schedule of maximum charges but argues that because Progressive's policy contains a fee schedule election notice,

it must pay **all** charges in accordance with the statutory schedule of maximum charges. This is a variation on the provider's argument in *MRI II*, which was that State Farm could determine provider reimbursements either by consulting the factors in section 627.736(5)(a) **or** by using the fee schedule limitations in section 627.736(5)(a)1, but was constrained to **exclusively** use one or the other of the two options. *MRI II*, 334 So. 3d at 581.

Our supreme court has rejected this notion and made clear that the schedule of maximum charges set forth in section 627.736(5)(a)1 provide "an **optional** method of capping reimbursements **rather than an exclusive method for determining reimbursement rates**." *Id.* at 585 (emphasis added). And as the court confirmed, "an election to use the limitations of the schedule of maximum charges [does not] preclude[] an insurer's reliance on the other statutory factors for determining the reasonableness of reimbursements." *Id.* at 584.

As Progressive correctly argues, the import of these pronouncements is that Progressive's policy-based notice that it will deem unreasonable those charges that exceed the schedule of maximum charges in subsection 627.736(5)(a)1 does not preclude it

from relying on section 627.736(5)(a) to determine a reasonable reimbursement for BOT's charges billed below the applicable fee schedule amount. Progressive further argues that it properly considered the factors identified in section 627.736(5)(a) to accept the amount BOT billed as a reasonable charge and that its reimbursement of 80 percent of the face amount of BOT's charges complied with the mandate of section 627.736(1)(a) to provide coverage for 80 percent of Ms. Bailey's reasonable medical expenses. Again, Progressive is correct.

In relevant part, section 627.736(5)(a) provides as follows:

> A physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance **may charge** the insurer and injured party **only a reasonable amount** pursuant to this section for the services and supplies rendered . . . . **[S]uch a charge may not exceed the amount the person or institution customarily charges for like services or supplies. In determining whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider** involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

Id. (emphases added). Progressive's payment of BOT's charges at 80 percent of the amount that BOT itself chose to bill unquestionably satisfied Progressive's obligation under the coverage mandate—that is, to reimburse BOT for 80 percent of the reasonable expenses BOT incurred in treating Progressive's insured, Ms. Bailey.

This is true for several reasons. First, BOT "may charge . . . only a reasonable amount," so Progressive could assume that BOT's charge was reasonable; it certainly was not required to assume that BOT charged an unreasonably low amount. § 627.736(5)(a). Second, BOT's charges "may not exceed the amount [it] customarily charges for like services or supplies," so Progressive legitimately could conclude that BOT charged Progressive what BOT "customarily charges" for like services. *Id.* Third, in determining a reasonable reimbursement for BOT's charges, Progressive was authorized to consider "evidence of usual and customary charges and payments accepted by [BOT]," and there is no better evidence of BOT's "usual and customary charges" than BOT's charges themselves. *Id.*; *see Nationwide Mut. Ins. Co. v. Jewell*, 862 So. 2d 79, 86 (Fla. 2d DCA 2003) ("[T]here is simply no basis for

complaining that a payment rate a [PIP medical] provider has agreed to accept is inadequate and therefore not reasonable."), *approved by Allstate Ins. Co. v. Holy Cross Hosp., Inc.*, 961 So. 2d 328, 330 (Fla. 2007).

VI.

Having determined that Progressive reimbursed BOT a reasonable amount for the services it rendered to Ms. Bailey in compliance with the PIP statute's reasonable medical expenses coverage mandate, we now address BOT's arguments that Progressive was nonetheless required to pay BOT more than 80 percent of the amount BOT billed.

BOT contends for the first time on appeal that Progressive is precluded to argue that it properly paid BOT's charges at 80 percent of the amount billed where that amount was below the fee schedule amount because Progressive asserted an affirmative defense stating that it had paid BOT's charges pursuant to the fee schedule limitations. We reject this argument.

Before filing suit, BOT submitted a statutorily required presuit notice,[10] to which it attached Ms. Bailey's "patient bill" in a form substantially identical to the patient bill attached to BOT's complaint. In its presuit notice, BOT asserted that Progressive had underpaid PIP benefits in the amount of $1,570 and stated that the amount claimed "was derived by taking 80% of the total charges, less prior payments, if any." In other words, BOT's initial position was that Progressive was required to pay **all** of BOT's charges at 80 percent of the amount billed and could not use the fee schedule limitations. BOT's complaint generally alleged that Progressive underpaid multiple charges but provided no detail as to specific underpayments. Given BOT's presuit notice and the generality of its allegations, Progressive necessarily concluded that BOT challenged its use of the fee schedule limitations on those bills where Progressive had applied the limitations; Progressive thus asserted an affirmative defense directed to BOT's challenge.

Over a year later, BOT moved for summary judgment on three distinct groups of charges: the hydrotherapy charges, the MPPR

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[10] *See* § 627.736(10).

charges, and the BA charges. As the summary judgment filings on the MPPR charges make plain, Progressive paid those charges using the fee schedule limitations; though BOT conceded the propriety of Progressive's use of the fee schedules, it maintained that Progressive "incorrectly" applied the MPPR limitation. BOT abandoned its MPPR claims at the hearing on its motions for summary judgment. At that point, Progressive's affirmative defense concerning the fee schedule limitations was no longer relevant because BOT no longer sought recovery for Progressive's allegedly incorrect use of the limitations. In sum, BOT's contention that Progressive's "fee schedule" affirmative defense—directed to claims BOT affirmatively abandoned—somehow bound Progressive to a particular reimbursement "methodology" is unpersuasive.

BOT also contends that Progressive's policy did not permit it "to pay 80% of the billed amount for [BOT's] charges below the fee schedule." This contention misapprehends the policy language and ignores the reasoning of *MRI II*. Progressive's policy—much like the policy at issue in *MRI II*—provides for coverage of 80 percent of reasonable medical expenses and effectively states that Progressive will use the fee schedule limitations as a cap on reimbursements.

Compare Progressive policy text reproduced above, *with* State Farm policy text reproduced at *MRI II*, 334 So. 3d at 580–81. And *MRI II* teaches us that under such circumstances, the fee schedule limitations "establish[] a ceiling but not a floor" and the insurer is free to determine reasonableness by consulting the factors listed in section 627.736(5)(a). *Id.* at 584–85. As discussed above, that is exactly what Progressive did with BOT's charges at issue in this case. And unlike the Geico policy at issue in *Irizarry* and its progeny, Progressive's policy does not include a provision stating that it will pay the full amount of a charge that is less than the amount allowed under the statutory schedule of maximum charges.

Finally, BOT argues that *Irizarry* (as clarified and expanded in *Hands On*, *Muransky*, and *Affinity*) supports the trial court's conclusion that Progressive could not pay BOT's charges at 80 percent of the billed amount and was instead required to "pay 80% of the applicable fee schedule amount . . . or pay the charge at 100% of the full amount billed for those charges billed below 80% of the schedule of maximum charges." We find BOT's argument unpersuasive because it is based on the proposition that "nothing in the [PIP] statutory scheme . . . permits a PIP insurer to limit

reimbursements to 80 percent of the billed amount." *Hands On*, 327 So. 3d at 440. We believe this is a flawed interpretation of the applicable statutory provisions and that this interpretation is at odds with the supreme court's analysis in *MRI II*.

In *Irizarry*, the Fifth District examined section 627.736(5)(a)5, which states that "[i]f a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the full amount of the charge." The *Irizarry* court interpreted this to mean that "if the billed amount is *less than 80% of the fee schedule* (the required amount an insurer must pay), the insurer may opt to pay the lower billed amount in full." *Irizarry*, 290 So. 3d at 984. *Hands On* refined this interpretation of subsection (5)(a)5, explaining that the provision applies *only* if the billed amount is less than 80% of the applicable fee schedule. *Hands On*, 327 So. 3d at 443–44. The court reasoned that subsection (5)(a)5 is "inapplicable" where the billed amount is "more than 80 percent of the [applicable] fee schedule." *Hands On*, 327 So. 3d at 442–43. In that instance, *Hands On* requires the insurer to always pay "80 percent of . . . the applicable fee schedule." *Id.* at 443.

We disagree with the Fifth District's interpretation of subsections (5)(a)1 and (5)(a)5. By saying that an insurer "**may**" pay the full amount of a charge "for an amount less than the amount allowed under subparagraph 1." (i.e., less than 80 percent of the applicable schedule of maximum charges), subsection (5)(a)5 permits—but does not require—an insurer to pay the full amount of the charge. As this court explained in a PIP provider reimbursement dispute many years ago, "[t]here is nothing uncertain or ambiguous about the word 'may,' ," which is "permissive." *Jewell*, 862 So. 2d at 85.

We must read "all parts of a statute . . . together in order to achieve a consistent whole." *Irizarry*, 290 So. 3d at 983 (quoting *Forsythe v. Longboat Key Beach Erosion Control Dist.*, 604 So. 2d 452, 455 (Fla. 1992)). Like subsection (5)(a)5, subsection (5)(a)1 also is permissive: it provides that insurers "may limit reimbursements" in accord with the schedule of maximum charges. Neither subsection (5)(a)1 nor subsection (5)(a)5 **require** an insurer to reimburse **any** charge in accordance with the fee schedule limitations or at 100 percent of the billed amount; had the legislature intended to mandate such a requirement, it certainly

could have done so. *See Jewell*, 862 So. 2d at 85. And for the same reason that "[t]he juxtaposition of two permissive provisions ordinarily cannot be understood as establishing a prohibition," *id.*, the juxtaposition of two permissive provisions cannot be understood as establishing a mandate.

Although subsection 5(a)5 permits, but does not require, an insurer to pay the full amount of a charge for less than the amount allowed under subsection (5)(a)1, if the insurer doesn't opt to pay the full amount, it nonetheless must meet the statutory coverage mandate—which is to pay 80 percent of a reasonable amount for the charge. As discussed above, *MRI II* instructs that an insurer whose policy contains a fee schedule election has the option to consult the factors in 627.736(a) to determine a reasonable reimbursement amount. Progressive exercised that option by paying 80 percent of the full amount of BOT's charge, consistent with the coverage mandate to pay 80 percent of reasonable medical expenses. Having voluntarily chosen the amount it deemed reasonable for the services provided to Ms. Bailey, BOT can hardly be heard to complain that Progressive's payment was unreasonable. *See id.* at 86. Moreover, we lack the power to read into section

627.736(5)(a) a requirement that an insurer must pay **any** charge at 100 percent of the face amount of the bill, just as we lack the power to read into that statutory provision a requirement that an insurer whose policy contains a fee schedule election notice must **always** pay a charge in an amount exceeding 80 percent of the applicable schedule of maximum charges in accordance with that schedule. *See MRI II*, 334 So. 3d at 884–85; *see also Jewell*, 862 So. 2d at 85 ("[C]ourts of this state are without power to construe an unambiguous statute in a way which would extend, modify, or limit its express terms or its reasonable and obvious implications. To do so would be an abrogation of legislative power." (cleaned up) (quoting *Holly v. Auld*, 450 So. 2d 217, 219 (Fla. 1984))).

For these reasons, we certify conflict with *Hands On* to the extent it

> hold[s] that when an insurer chooses to reimburse according to scheduled rates, it must pay 80 percent of 200 percent of the statutorily adopted applicable fee schedule. There is nothing in the statutory scheme that permits a PIP insurer to limit reimbursements to 80 percent of the billed amount.

Hands On, 327 So. 3d at 440 (footnote omitted). We also certify conflict with *Affinity* and *Muransky* to the extent those decisions contain the same holding.

VII.

In conclusion, we hold that a PIP insurer whose policy includes a notice that it will limit medical provider reimbursements in accordance with section 627.736(5)(a)1 is not required to calculate all provider reimbursements in accordance with the statutory schedule of maximum charges. A PIP insurer must pay 80 percent of reasonable medical expenses for all charges that are reimbursable under the statute. The insurer may consider all factors identified in section 627.736(5)(a) to determine a reasonable reimbursement amount for any charge, including a charge for less than the allowable amount under subsection (5)(a)1 or a charge for less (or more) than 100 percent of the allowable amount pursuant to the applicable schedules identified in subsection (5)(a)1.a through f.

Progressive's reimbursement of BOT's charges at 80 percent of the amount that BOT billed was reasonable as a matter of law under section 627.736(5)(a) and the supreme court's analysis in

MRI II, as well as this court's analysis in *Jewell*. Accordingly, we reverse and remand this case with instructions to grant Progressive's motion for summary judgment and enter final judgment in favor of Progressive.

Reversed and remanded; conflict certified.

VILLANTI and LaROSE, JJ., Concur.

Opinion subject to revision prior to official publication.