Limiting Charge & the Future of Florida PIP Litigation

Some medical reimbursements that were previously considered proper are now being challenged as insufficient.

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Personal injury protection (PIP) litigation in Florida has been a high-volume practice area. Unfortunately, the number of PIP lawsuits may surge to even greater numbers due to recent court rulings.

The decision by the Third District Court of Appeal (DCA) in *Priority Medical Centers, LLC a/a/o Susan Boggiardino v. Allstate Insurance Company* upheld the 2012 amendments to the Florida No-Fault Act requiring the carrier to reimburse a diagnostic imaging provider according to the 2007 non-facility limiting charge. The court held this applies when the amount is higher than the participating physician fee schedule. The decision will likely negatively impact insurance companies' liability for a potential underpayment in almost any claim from the past five years in which an X-ray or MRI code was reimbursed pursuant to the participating physician fee schedule.

Understanding the Limiting Charge

The limiting charge is a higher limit, or ceiling, for medical providers who do not accept Medicare's approved amount as payment in full. A medical provider may request higher reimbursement from Medicare in these instances. The limiting charge would dictate the maximum amount allowable when approved. This additional charge has a limit of 15% more than the Medicare-approved reimbursement. However, states can choose to set a lower limit. This different reimbursement rate has since created a surge of PIP lawsuits being filed, primarily on behalf of diagnostic imaging providers. These new lawsuits are seeking higher reimbursement of previously paid services. This surge is anticipated to soar higher in the next few months.

In 2004, the Third District Court of Appeal heard oral arguments in the case of *Millennium Diagnostic Imaging Center v. Security National Insurance Company*. In *Millennium*, the court held when an insurance company elected to limit reimbursements under PIP to the amounts allowed under the Medicare Part B fee schedule, then the reimbursement would be limited to 80% of 200% of the non-participating facility price and not the limiting charge. The court based its ruling on the language of Florida's PIP statute using the phrase, "participating physician fee schedule." In 2003, the Florida legislature removed "applicable" and

added "participating physician fee schedule" under §627.736(5)(a)(2) (2003). The court in *Millennium Diagnostic* held, "we believe that the amendment was enacted as a clarification of the legislature's intent on what an 'allowable amount' would be."

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However, in 2012 the Florida legislature amended the PIP statute and replaced the phrase "participating physician" with the word "applicable." As a result, medical providers began to argue that the opinion of the *Millennium Diagnostic* court was no longer valid. The argument was the legislative intent of the amendment was to provide a higher reimbursement whenever a CPT code was reimbursable at an amount less than the 2007 limiting charge. The trial court in *Priority Medical Centers* analyzed the current version of the PIP Statute with the 2012 amendment and ruled that the "allowable amount" of Medicare Part B is the limiting charge for 2007 if this amount is higher than the non-facility price. *Priority Med. Ctrs.*

Furthermore, the Florida PIP statute states that the reimbursement may not be less than the allowable amount under the 2007 Medicare fee schedule. The Third District Court of Appeal has affirmed this opinion. The decision has now made the limiting charge rate as the Medicare-approved reimbursement fee schedule. Under current Florida law, the limiting charge is now the proper reimbursement metric to determine reimbursement when the 2007 amount is higher than the participating physician's fee schedule.

The takeaway for insurance carriers is reimbursement which was previously a proper reimbursement has now retroactively been made insufficient. As a result, most prior reimbursements on either an MRI code, an X-ray code, or any other CPT code in which the reimbursement fell below the 2007 limiting charge are now improper. Additionally, the exposure for potential attorney fees and costs has now increased exponentially.

There has already been a huge uptick in lawsuits being filed on behalf of facilities that have provided the kinds of diagnostic services that are affected by the court's decision in *Priority Med Ctrs*. This trend will likely increase in the coming months. The only way for a carrier to protect itself in this new landscape is to provide the additional benefits in response to the statutory demand letter. Otherwise, a carrier is exposing itself to additional lawsuits in which they will likely be held liable not only for additional benefits but for attorney fees/costs as well.

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