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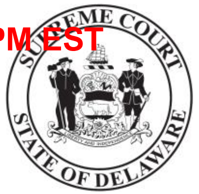

IN THE SUPREME COURT OF THE STATE OF DELAWARE

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY and STATE FARM FIRE AND CASUALTY COMPANY,	)	No. 469,2019
Defendants-Below, Appellants,	)	On Appeal from the Superior Court of the State of Delaware
	)	C.A. No. K18C-07-008 NEP
v.	)	
SPINE CARE DELAWARE, LLC	)	
Plaintiff-Below, Appellee.	)	

APPELLANTS' SECOND AMENDED OPENING BRIEF

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NATURE OF PROCEEDINGS

Delaware's PIP statute requires insurers to pay for "reasonable and necessary [medical] expenses" incurred by persons injured in automobile accidents within two years of the date of the accident.[1] Defendants State Farm Mutual Automobile Insurance Company and State Farm Fire and Casualty Company (collectively, "State Farm") bring this appeal because the trial court erred when it granted summary judgment in favor of Plaintiff Spine Care Delaware, LLC ("Spine Care") and issued a declaratory judgment that State Farm's practice of applying multiple procedure payment reductions ("MPRs") in paying Spine Care for bilateral and multilevel spinal injections violates Delaware's PIP statute.

It is undisputed that when a patient receives more than one spinal injection within the same operative session, there are pre-procedure and post-procedure services that are not repeated with each injection. It is also undisputed that MPRs[2] are the means under the CPT coding system by which providers avoiding paying

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[1] 21 *Del. C.* § 2118(a)(2)(A).

[2] MPR, as used in this brief, refers to both the bilateral procedure payment reduction for the second side of a bilateral spinal injection as well as multiple procedure payment reductions applied to the second and successive levels of spinal injections performed at multiple vertebral levels. Because Spine Care challenges State Farm's reductions to both bilateral and multilevel injections without distinction, the issue before this Court is the same for both bilateral injections and multilevel injections. For that reason, this brief refers to them both as MPRs for ease of discussion.

multiple times for services only performed once in the administration of bilateral and multilevel injections.

It is also undisputed that other private insurance companies and Medicare routinely apply MPRs to Spine Care's bills and reduce the amount that Spine Care receives for the second and subsequent injections by the very same percentage that State Farm does. Spine Care accepts these reductions without challenge. It is also undisputed that the amount State Farm pays Spine Care for spinal injections performed on State Farm's PIP insureds substantially exceeds what Spine Care freely accepts from those other private insurance companies and from Medicare. This is because State Farm pays 100% of Spine Care's standard rate for the first injection and also applies the MPRs to that full standard rate, whereas those other payors pay according to a negotiated fee schedule and then apply any MPRs to the much lower fee-schedule rates rather than Spine Care's higher billed rates.

For all of these reasons, State Farm pays "reasonable and necessary expenses" and complies with Delaware's PIP statute when it applies MPRs to bilateral and multilevel spinal injections in accordance with industry standard claims processing guidelines. But, at summary judgment, the trial court rejected all of this evidence and concluded that not only that State Farm had not carried a nonexistent burden of demonstrating the reasonableness of its MPRs, but also that somehow this meant that the use of MPRs violates Delaware's PIP statute. This logical leap is

unsupportable. The trial court concluded that Spine Care had not established that its fees are reasonable. That finding alone should have required the entry of summary judgment in State Farm's favor. But even if State Farm did have the burden of demonstrating that the MPRs resulted in a reasonable payment to Spine Care, State Farm easily satisfied that burden for the reasons discussed above. This Court should reverse the grant of summary judgment in favor of Spine Care and direct the entry of summary judgment in favor of State Farm.

SUMMARY OF THE ARGUMENT

1. The Superior Court erred in granting Spine Care's motion for summary judgment and in denying State Farm's motion for summary judgment on the issue of whether State Farm is permitted to apply MPRs to bills for bilateral and multilevel spinal injections performed in a single operative session. Spine Care bears the burden of demonstrating that the amount that it charges is reasonable. The trial court found that Spine Care did not satisfy that burden, but incorrectly placed the burden on State Farm to demonstrate that its application of MPRs result in a reasonable payment to Spine Care. This was error. But even if State Farm did bear that burden, State Farm satisfied it by offering undisputed evidence showing that MPRs are widely used and accepted both in the medical billing and payment industry generally and at Spine Care itself, to prevent Spine Care from receiving a windfall for duplicative work that it performs, and are in the best interest of Delaware insureds. At the very least, this evidence was sufficient to create a disputed issue of material fact that required the denial of Spine Care's motion for summary judgment.

STATEMENT OF FACTS

A. Background of the Parties

Spine Care is an ambulatory surgery center ("ASC") that focuses exclusively on minimally invasive spinal injections.[3] The physicians who use Spine Care's facility often administer multiple spinal injections in a single operative session. When multiple spinal injections are performed, they are administered either bilaterally (*i.e.*, one on each side of the spinal column) or at multiple vertebral levels.[4] Spine Care bills the patients (or their insurance companies) for its "facility fees" associated with the administration of the spinal injections.[5]

State Farm is an insurance company that issues automobile policies to Delaware insureds, including Personal Injury Protection ("PIP") coverage.[6] PIP coverage is designed to provide "[c]ompensation to injured persons for reasonable and necessary expenses incurred within two years from" an automobile accident for certain categories of expenses, including medical expenses and lost earnings.[7]

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[3] A141 ¶ 1.

[4] A141 ¶ 5.

[5] The physicians bill separately for their services, and their billing is not at issue in this case. A060:4-19; A062:19-22.

[6] A141 ¶ 2.

[7] *See* 21 *Del. C.* § 2118(a)(2)(a).

B. Spine Care's Billing Practices

When a patient visits Spine Care, Spine Care submits a bill for its facility fee to the payor that the patient identifies.[8] The fee compensates Spine Care for its costs, and is designed to be "inclusive of all of the parts of the procedure that take place" at Spine Care, "starting from the pre-operative phone calls prior to the procedure, the registration, history and physicals, supplies, postoperative care, postoperative phone calls, [and] medications."[9]

The amount that Spine Care charges for its facility fee is determined by the procedure that is performed. Each procedure corresponds to a CPT code, which is a standardized code created by the American Medical Association that is used to designate various types of medical procedures.[10] Spine Care has set standard rates for its facility fees for each of the CPT codes that it bills for spinal injections.[11]

The payor that is billed for the facility fee is often a third-party payor, such as insurance company. Spine Care has contractual relationships with three private insurance companies – Aetna, Blue Cross Blue Shield, and Coventry – making Spine Care an "in network" participating provider that is reimbursed pursuant to an agreed fee schedule irrespective of the standard rates Spine Care includes on its bills.[12]

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[8] *See* A059:23-A060:6.
[9] A060:8-14.
[10] A067:9-14.
[11] A067:9-A068:22.
[12] A088:3-11; A142 ¶ 13.

Spine Care also accepts Medicare patients and bills Medicare directly for the facility fee, with Medicare paying Spine Care according to Medicare's reimbursement rate and not the amount Spine Care bills.[13] Spine Care invoices payors at its full standard rates.

C. Third-Party Payors' Reimbursement Practices

Although Spine Care invoices all third-party payors at its full standard rates, Spine Care knows that if a fee schedule applies, it will be paid according to that schedule rather than the amount billed.[14] Fee schedules vary from payor to payor, but are often substantially less than the standard rates that Spine Care invoices.[15] For example, when Spine Care performs a single lumbar SNRB injection that corresponds to CPT Code 64483, Spine Care invoices $1,439.90.[16] Aetna only pays Spine Care $531.00 for that injection.[17] That is 63.2% less than the amount that Spine Care bills. Other private insurance companies and Medicare also pay Spine Care far less than the amount that Spine Care bills.[18] Spine Care accepts these substantially reduced amounts as full payment from these private health insurance companies and from Medicare.[19]

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[13] A142 ¶ 13.
[14] A065:22-A066:13; *see also* A069:7-11.
[15] *Id.*
[16] A147-49.
[17] *Id.*
[18] A151-56.
[19] A098:1-A099:18.

In sharp contrast to other third-party payors, State Farm consistently pays Spine Care its full requested amount of the facility fee for the first injection.[20] Thus, in the same example as above, if a patient receives a single lumbar SNRB injection that corresponds to CPT Code 64483, State Farm pays Spine Care the full $1,439.90 that Spine Care invoices for that procedure, *not* a reduced amount.[21] This is because unlike "in network" private insurance companies, State Farm has not contractually agreed to a reduced fee schedule with Spine Care and, unlike Medicare, does not pay pursuant to a fee schedule that is established by law. State Farm and other PIP insurers are unique in paying Spine Care for the full amount of the facility fee that Spine Care charges for the first spinal injection.[22]

D. Bilateral and Multiple Procedure Reductions ("MPRs")

When a patient receives multiple injections in a single operative session, each injection is coded as a separate procedure on the bill, but much of the work is not repeated for each additional injection that is performed. For that reason, it is standard in the medical coding and payment industry to apply a bilateral or multiple procedure reduction ("MPR") to reduce the amount paid to the provider for the second and successive injections to account for the overlap and avoid

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[20] A071:3-16; A158.
[21] *See* A158.
[22] A072:2-12.

overpayment.[23] An MPR is applied in coding the payment for bilateral and multilevel spinal injections not because the patient presents insurance accepted by the provider or a Medicare card, but rather because of the nature of the services. Regardless of what type of insurance is being presented – or no insurance at all – the bilateral or multilevel injections being performed will necessarily involve overlap that the medical coding and payment industry recognizes requires the application of an MPR to avoid the provider being paid twice for some of the work.

The Centers for Medicare & Medicaid Services ("CMS") provide claims processing guidelines (the "Guidelines") that serve as the foundation of medical coding and billing in Delaware and across the United States.[24] State Farm follows them in paying claims because they "provide consistent, uniform standards for providers and insurers to apply in billing and reimbursing medical services."[25] Under the Guidelines, procedures "performed bilaterally in one operative session [are] reported as two procedures."[26] When bilateral procedures are performed as part of the same operative session, the Guidelines state that payment to the provider for the second procedure should be reduced because some of the work associated

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[23] *See* A164, A166.
[24] *See* A164, A166.
[25] A302 ¶ 3.
[26] A141 ¶ 6.

with the procedures is not performed twice.[27] Thus, under the Guidelines, "[t]he ASC is paid 100% for the first side and 50% for the second side."[28]

The Guidelines also address the appropriate way to pay claims where "more than one surgical procedure is performed in the same operative session."[29] In that circumstance, "when an ASC performs multiple surgical procedures in the same operative session, the ASC is paid 100% of the highest paying surgical procedure on the claim, plus 50% of the applicable payment rate(s) for the other ASC covered surgical procedures."[30] The justification for this reduction is similar to the justification for the bilateral procedure reduction: "[S]ome of the work that is necessary to perform spinal injections at multiple vertebral levels (such as set-up work) is also necessary for the spinal injection at the first level and does not have to be repeated for each additional injection that is performed as part of the same operative session."[31]

Because they prevent overpayment for services that overlap across two separately reported medical procedures occurring in the same operative session, payors of all types routinely apply MPRs. When payors apply MPRs to bills issued by Spine Care, they reduce the amount that is payable for the second and subsequent

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[27] *Id.*; A164.
[28] A141 ¶ 6.
[29] A141 ¶ 8.
[30] A141 ¶ 7.
[31] A166.

injections below the already-discounted amount that they pay Spine Care on the first injection.[32] Spine Care accepts the reductions from these payors.[33]

State Farm applies MPRs when it pays Spine Care, based on this rationale – an overlap in services across the injections performed in the same operative session. Specifically, State Farm applies the Guidelines which call for reducing the amount payable on the second and subsequent injections to 50% of the full amount of Spine Care's facility fee.[34] But, unlike other types of payors, when State Farm applies the MPRs, it does so only after it has paid Spine Care its full standard rate for the first injection.[35] Because Medicare and the insurance companies with which Spine Care participates "in network" pay Spine Care according to fee schedules at amounts that are substantially lower than Spine Care's standard rates, State Farm pays Spine Care substantially more than these other payors for each and every injection. In fact, the reduced amount that State Farm pays on the second and subsequent injections after applying an MPR (*i.e.*, 50% of Spine Care's standard rate) exceeds what some other payors pay Spine Care on *the first injection*, before an MPR is even applied.[36]

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[32] *See* A147-A156.
[33] A091:3-22; A102:4-17.
[34] *See* A158; A302-03.
[35] To be precise, this means that for bilateral injections, Spine Care is paid 100% of the amount that it bills for the injection performed on the first side, and for injections performed at multiple vertebral levels, Spine Care is paid 100% for the most expensive injection that it bills.
[36] *Compare* A158 *with* A147-56.

MPRs are not discounts and are completely distinct and bear no relationship to negotiated discounted rates under fee schedules that Spine Care agrees to as an in-network provider for health insurers and the Medicare reimbursement rate set by the government. The medical coding and billing industry uses CPT coding and because each injection is billed as a separate procedure code, MPRs are the claims processing payment methodology used by payors to avoid paying multiple times for services provided only once in administering bilateral and multilevel injections in a single operative session. Thus, the purpose and justification for MPRs does not depend on a contract; rather, any payor, regardless of their relationship with Spine Care, has a right to seek to avoid overpaying for spinal injections by paying more than once for services only provided a single time in the provision of bilateral and multilevel injections. Applying an MPR is the way that is done.

E. Procedural History

Spine Care filed this action on July 11, 2018, seeking a declaratory judgment on whether State Farm can apply MPRs to Spine Care's bills for multiple spinal injections performed in a single operative session. Spine Care contends that State Farm's practice of applying MPRs violates Delaware's PIP statute because, according to Spine Care, it "results in unreasonably reduced payments."[37]

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[37] A030 ¶ 24, A032 ¶ 32.

The parties cross-moved for summary judgment. Though Spine Care sought a declaratory judgment on whether State Farm is entitled to apply MPRs to the second and successive spinal injections performed in a single operative session, Spine Care offered no evidence about whether any other providers refuse to accept MPRs from PIP insurers. In fact, Spine Care offered very little evidence about MPRs at all. Spine Care focused instead on the reasonableness of its standard rates, which was curious since State Farm pays Spine Care's standard rates. Spine Care compared its standard rates to the standard rates of two other ambulatory surgery centers in New Castle County and argued that its standard rates were reasonable because they "fall within the range of fees charged by its two competitors in New Castle County."[38]

State Farm cross-moved and emphasized that the actual issue before the Court is not whether Spine Care's standard rates are in line with its competitors, but rather whether Delaware's PIP statute somehow precludes State Farm from applying industry accepted MPRs to bilateral and multilevel injections, which merely account for the overlap and avoid overpaying on these particular injections.[39] State Farm noted that nothing in the PIP statute precluded MPRs and emphasized that its obligation under the PIP statute is to pay for "reasonable and necessary expenses"

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[38] A287.
[39] A127-28.

incurred by its insureds.[40] State Farm argued that by focusing on proving up the reasonableness of its standard rates, Spine Care had ignored the real issue. Because it was reasonable for State Farm to apply the MPRs that the medical coding industry has created for avoiding overpayment for bilateral and multilevel spinal injections and other similar services, and because doing so will preserve the insured's PIP coverage and is in the best interest of insured, State Farm argued that it was entitled to summary judgment.[41]

On October 29, 2019, the trial court denied State Farm's motion for summary judgment and granted Spine Care's motion for summary judgment. The trial court looked to two unpublished Superior Court decisions, *Anticaglia v. Lynch*[42] and *Watson v. Metropolitan Property and Casualty Insurance Company*[43] for a description of various factors that "guide a court's or jury's determination of the reasonableness of medical fees."[44] The trial court recognized that Spine Care had not demonstrated that the standard rates it charges are reasonable because Spine Care had offered evidence about "only one of those factors, namely, the ordinary and

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[40] A120-22.
[41] *See* A130-36.
[42] 1992 Del. Super. LEXIS 122 (Del. Super. Ct. Mar. 16, 1992).
[43] 2003 Del. Super. LEXIS 344 (Del. Super. Ct. Oct. 2, 2003).
[44] Opinion and Order Upon Plaintiff's Motion for Summary Judgment and Defendants' Motion for Summary Judgment at 6 (Oct. 29, 2019) (hereinafter "Trial Court Order").

reasonable charges of similarly situated professionals."[45] The trial court expressly found that Spine Care was not entitled to the summary judgment that it had requested.

Nevertheless, the trial court granted summary judgment in favor of Spine Care, erroneously concluding that "State Farm's practice of applying Medicare-prescribed MPRs to reduce Spine Care's bills for bilateral and multilevel procedures violates" Delaware's PIP statute.[46] The trial court reached this conclusion because it stated, without citing to any authority, that "any adjustment to the bill by the insurer must have a basis in fact that conforms to the *Anticaglia* and *Watson* factors."[47] The trial court then concluded that "State Farm has failed to present evidence demonstrating that its MPRs correlate with reasonable charges for bilateral and multilevel injections." The trial court implicitly concluded – without reference to any provision of Delaware PIP statute, that State Farm could not rely on the widely accepted industry standard Guidelines as its rationale for applying MPRs.[48]

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[45] Trial Court Order at 5 n.15.
[46] Trial Court Order at 10.
[47] Trial Court Order at 7.
[48] *Id.*

ARGUMENT

I. THE TRIAL COURT ERRED BY GRANTING SUMMARY JUDGMENT TO SPINE CARE BECAUSE SPINE CARE WHOLLY FAILED TO MEET ITS BURDEN TO ESTABLISH THAT STATE FARM'S APPLICATION OF MPRs IS UNREASONABLE AND INCONSISTENT WITH ITS OBLIGATION UNDER DELAWARE PIP LAW TO PAY "REASONABLE AND NECESSARY EXPENSES."

A. Questions Presented

Whether Spine Care was entitled to summary judgment on the issue of whether "State Farm's practice of applying Medicare-prescribed MPRs to reduce Spine Care's bills for bilateral and multilevel procedures violates 21 *Del. C.* § 2118(a)(2)" where the trial court held that Spine Care had not demonstrated that its "fees for bilateral and multilevel procedures are reasonable as a matter of law."[49]

B. Scope of Review

This Court reviews a trial court's decision to grant summary judgment *de novo*.[50] Summary judgment is required "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law."[51]

[49] Trial Court Order at 5 n.15. Preserved at A120-35; A311-12.
[50] *See, e.g.*, *GMG Capital Invs., LLC v. Athenian Venture Partners I, L.P.*, 36 A.3d 776, 779 (Del. 2012).
[51] Del. Super. Ct. Civ. R. 56(c).

C. Merits of the Argument

1. The Trial Court Incorrectly Placed the Burden on State Farm to Demonstrate that its Application of MPRs Is Reasonable.

Delaware's PIP statute requires owners of motor vehicles to maintain insurance coverage that provides "[c]ompensation to injured persons for reasonable and necessary expenses incurred within 2 years from the date of the accident for . . . medical" and other services and for lost earnings.[52] This Court has previously recognized that it is the plaintiff – in this case, Spine Care – who bears the burden of establishing that a PIP insurer has failed to pay "reasonable and necessary expenses."[53] In *Ramsey v. State Farm Mutual Insurance Company*, the plaintiff challenged her insurer's decision to deny her request for lost wages under her PIP coverage that she incurred when she missed work to attend medical appointments during the workday.[54] The trial court granted summary judgment to the insurer, finding that the plaintiff "failed to establish that her lost earnings were unavoidable" because she "presented no evidence that the appointments . . . had to be scheduled

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[52] 21 *Del. C.* § 2118(a)(2)(A); *see also State Farm Mut. Auto. Ins. Co. v. Buckley*, 140 A.3d 431, 431 (Del. 2016) ("The Delaware Code requires that motor vehicle insurance include coverage for PIP benefits, which provide compensation to automobile occupants who are injured in an accident for various expenses, including medical bills and lost earnings.").

[53] *See Ramsey*, 2005 Del. LEXIS 83 at *3; *Murphy*, 2005 Del. Super. LEXIS 159 at *8 ("As a matter of law, the burden lies on the Plaintiff, not the insurer, to show the expenses were 'reasonable and necessary.'" (quoting 21 *Del. C.* § 2118(a))).

[54] *Ramsey*, 2005 Del. LEXIS 83, at *1.

during work hours."[55] On appeal, the plaintiff argued that the trial court erred because, according to the plaintiff, the insurer "had the burden to establish that she could have arranged her medical treatment before or after work."[56] This Court rejected that argument, explaining that "[t]he PIP statute provides recovery only for 'reasonable and necessary' expenses," and that to demonstrate entitlement to payment, the insured "had to establish that her lost wages were unavoidable."[57] In other words, this Court held in *Ramsey* that the insurer is not required to establish *anything* before failing to pay requested charges from an insured's PIP benefits.

Here, the trial court denied State Farm's motion for summary judgment, and granted summary judgment in Spine Care's favor, because, according to the trial court, "State Farm has failed to present evidence demonstrating that its MPRs correlate with reasonable charges for bilateral and multilevel injections."[58] As discussed below, State Farm presented substantial evidence supporting its rationale for applying MPRs and justifying the reductions at issue. Thus, even if the burden rested with State Farm to prove the reasonableness of its payments, there would be no basis for summary judgment in favor of Spine Care. But because Spine Care bears the burden of demonstrating that State Farm fails to pay "reasonable and

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[55] *Id.* at *2.
[56] *Id.* at *2-3.
[57] *Id.* at *3.
[58] Trial Court Order at 7.

necessary expenses" when it applies MPRs to bilateral and multilevel spinal injections to account for services not repeated with each injection, the trial court committed reversible error in its framing of the issue in the first instance.

2. Spine Care Did Not Carry Its Burden of Demonstrating that State Farm Fails to Pay "Reasonable and Necessary Expenses" in Applying MPRs to Claims for Bilateral and Multilevel Injections.

The trial court's order should be reversed because Spine Care did not demonstrate as a matter of law that State Farm's fails to pay "reasonable and necessary expenses" when it applies MPRs to bilateral and multilevel spinal injections. Spine Care insisted that the issue before the trial court was whether its standard rates for all spinal injections were reasonable and focused its argument on showing the trial court that its standard rates for the CPT codes at issue "fall within the range of fees charged" by those two other ambulatory surgery centers in New Castle County and that, therefore, "[t]he Court should thus find, as a matter of law, that the disputed fees (for bilateral or multilevel procedures) are reasonable."[59]

As explained above, the trial court concluded that "the record would ***not*** support a determination that Spine Care's fees for bilateral and multilevel procedures are reasonable as a matter of law" and that Spine Care was not entitled to summary

[59] A287, A289.

judgment on that issue.[60] That should have been the end of the matter.[61] Inexplicably, however, the trial court determined that Spine Care was nevertheless entitled to summary judgment because, according to the trial court, *State Farm* had failed to sufficiently establish that "its MPRs correlate with reasonable charges for bilateral and multilevel injections" based on an application of factors set forth in two inapposite unpublished Superior Court decisions, *Anticaglia v. Lynch*[62] and *Watson v. Metropolitan Property and Casualty Insurance Co.*[63]

a. The Trial Court Relied on Inapposite Authority.

Anticaglia and *Watson* are inapplicable. Both cases involve disputes over specific medical bills. In *Anticaglia*, a physician sued his patient to recover the full amount of the "reasonable and customary" fees for services the physician had provided.[64] The patient argued that the physician's charges were unreasonably high.

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[60] *See* Trial Court Order at 5 n.15.

[61] *See Burkhart v. Davies*, 602 A.2d 56, 59 (Del. 1991) ("[T]he plain language of Rule 56(c) mandates the entry of summary judgment . . . against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial."); *see also Ramsey*, 2005 Del. LEXIS 83, at *3 (affirming grant of summary judgment to insurer where plaintiff "offered no evidence" that the lost wages for which she sought coverage under Delaware's PIP statute were "necessary" and therefore "failed to establish her entitlement to PIP benefits").

[62] 1992 Del. Super. LEXIS 122 (Del. Super. Ct. Mar. 16, 1992).

[63] 2003 Del. Super. LEXIS 344 (Del. Super. Ct. Oct. 2, 2003).

[64] *Anticaglia*, 1992 Del. Super. LEXIS 122, at *1.

In agreeing with the patient, the Superior Court set forth a list of factors that bear on the reasonableness of a physician's charges, including:

> the ordinary and reasonable charges usually made by members of the same profession of similar standing for services such as those rendered here, the nature and difficulty of the case, the time devoted to it, the amount of services rendered, the number of visits, the inconvenience and expense to which the physician was subjected, and the size of the city or town where the services were rendered. The Court also should consider the physician's education and training, experience, skill or capacity, professional standing or reputation, and the extent of the physician's business or practice. Finally, the Court should consider the ability of the defendant to pay.[65]

In *Watson*, the Superior Court denied summary judgment to an insurer in a challenge to the insurer's refusal to pay the full amount charged by her medical provider under Delaware's PIP statute.[66] The court cited the *Anticaglia* factors as providing "guidelines of the kind of proof that would be reliable" in establishing that a medical provider's fees were reasonable under Delaware's PIP statute.[67] It then concluded that the insurer was not entitled to summary judgment because the physician who had provided medical services to the patient had submitted an affidavit supporting the plaintiff's assertion that the charges at issue were reasonable and would testify at trial, in part, that the "charges are the very same charges paid

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[65] *Id.* at *19.
[66] 2003 Del. Super. LEXIS 334, at *1-2.
[67] *Id.* at *21.

by the majority of insurance companies with which he deals, as well as self-insureds, everyday in his practice."[68]

Anticaglia does not involve the interpretation of Delaware's PIP statute at all. That case involved a physician's attempt to collect on an unpaid medical bill pursuant to a *quantum meruit* theory.[69] And while *Watson* did involve a challenge to an insurance company's refusal to pay the full amount a medical provider billed for a PIP-covered claim on the grounds that the provider's charges were "excessive," it does not suggest that an insurer is required to demonstrate the reasonableness of its reductions to a fee that the insurer believes is excessive. Indeed, this Court has made clear that "[t]he words 'reasonable and necessary' qualify the scope of the delineated benefits that an insurance company must pay," (*i.e.*, the amount of a provider's charges), not the amount of the reduction that the insurance company applies to an unreasonably high charge.[70]

Moreover, the issue in this case is far different from *Anticaglia* and *Watson*. This case does not involve the reasonableness of a specific bill to a specific provider for services previously rendered. It involves State Farm's application of an industry-standard payment methodology (MPRs) in certain circumstances (when multiple spinal injections are performed in a single operative session). *Anticaglia* and *Watson*

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[68] *Id.* at *12, 22 (internal quotation marks and citations omitted).
[69] 1992 Del. Super. LEXIS 122, at *12.
[70] *See Murphy*, 2005 Del. Super. LEXIS 159, at *10.

do not address, much less impugn, a PIP insurer's ability to rely on widely accepted industry standard claim processing Guidelines in paying medical claims.

b. Even Under the Framework the Trial Court Applied, Spine Care Did Not Carry its Burden.

Even if *Anticaglia* and *Watson* were controlling, they do not support the trial court's grant of summary judgment to Spine Care. The only evidence that Spine Care offered in support of its assertion that State Farm's application of the MPR's violates Delaware's PIP statute is evidence that, for various CPT codes, Spine Care's standard billing rate is in line with the standard billing rates of two other ambulatory surgery centers that Spine Care contends are its competitors.[71] This evidence is insufficient to demonstrate that State Farm's application of MPRs to the second and subsequent spinal injections performed in a single operative session is unreasonable for several reasons.

As an initial matter, Spine Care only attempts to address one of the factors that *Anticaglia* and *Watson* describe as being relevant to assessing the reasonableness of a provider's charges – the ordinary charges made by members of the same profession for similar services. Spine Care ignores all of the others. Thus, as the trial court recognized, "the record [does] *not* support a determination that

[71] *See* A287-89.

Spine Care's fees for bilateral and multilevel procedures are reasonable as a matter of law."[72]

Moreover, the evidence that Spine Care offered about the amount that its purported competitors charge for the same CPT codes has ***no bearing*** on whether State Farm's application of MPRs to the second and subsequent injections performed in a single operative session results in an unreasonably low payment. Importantly, Spine Care offered no evidence that the other ambulatory surgery centers refuse to accept the application of MPRs. Indeed, the only evidence in the record about any other providers' acceptance of MPRs is in the report of State Farm's medical coding expert witness Nicole Bonaparte. This evidence confirms that Spine Care's practice of refusing to accept the MPRs and insisting on full payment for every injection "is not customary in the industry."[73] Hence, even under the only factor that Spine Care looked to in support of its position, Spine Care's refusal to accept MPRs from PIP insurers is unreasonable as a matter of law.

The trial court also erroneously ignored the several other *Anticaglia* and *Watson* factors that further support State Farm's application of MPRs. Those cases both indicate that, in addition to looking at the amount that other types of payors actually pay for the services in question, a provider's reasonableness of fees depends

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[72] Trial Court Order at 5 n.15 (emphasis in original). Spine Care has not cross-appealed this ruling.
[73] A164, A166.

in part on "the nature and difficulty of the case, the time devoted to it, the amount of services rendered, the number of visits, [and] the inconvenience and expense to which the physician was subjected."[74] All of these factors support State Farm's decision to apply MPRs. As discussed above, MPRs exist to prevent the provider from obtaining a windfall for work that is not repeated when the provider performs multiple spinal injections in a single operative session. Performing the second and successive injections in a single operative session is, on balance, less difficult, requires less time, and involves the rendering of less services as compared to the first injection, because a number of the tasks that are required to be performed for the first injection are not repeated for the second.[75] Thus, all of these factors support, rather than undercut, State Farm's application of the MPRs.

The trial court dismissed this evidence because State Farm did not "retain an expert to explain how a fifty percent reduction for one of the injections in a bilateral procedure, or a fifty percent reduction for all but one of the injections in a multilevel procedure, correlates directly to reduced costs for Spine Care and reduced efforts for medical providers in Spine Care's facility."[76] Incredibly, in rejecting State Farm's reliance on the widely accepted and industry standard Medicare Claims Processing

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[74] *Anticaglia*, 1992 Del. Super. LEXIS 122, at *19; *see also Watson*, 2003 Del. Super. LEXIS 344, at *21.
[75] *See, e.g.*, A164, A166.
[76] Trial Court Order at 7.

Guidelines as the rationale for the reduction,[77] the trial court even went so far as to refer to them as "arbitrar[y],"[78] based on nothing more than the fact that some payors apply *greater* reductions than the fifty percent set forth in the Guidelines.

The trial court's analysis and conclusion is legally flawed for several reasons. As discussed above, State Farm does not bear the burden of demonstrating that its MPRs are reasonable. Spine Care bears the burden of demonstrating that State Farm's application of them constitutes a failure to pay "reasonable and necessary expenses." Spine Care has not even seriously attempted to satisfy that burden. Moreover, the trial court's insistence that State Farm demonstrate that the amount of the reduction "correlates directly to reduced costs for Spine Care"[79] is inconsistent with basic realities and principles of medical coding and billing. Spine Care's standard rates are flat amounts that do not "correlate[] directly" to Spine Care's costs or to the efforts that Spine Care is required to expend in performing the spinal injections. The cost to Spine Care for each of the spinal injections at issue varies because "every single patient and every single procedure is different."[80] And regardless, on average, Spine Care's standard rates vastly exceed the actual cost to Spine Care for performing at least some of the injections at issue, which further

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[77] A164-65.
[78] Trial Court Order at 8.
[79] *Id.*
[80] A094:2-15.

disproves any suggestion that there is a direct correlation between Spine Care's standard rates and its costs in performing the procedures.

Spine Care's corporate representative admitted that, for bilateral spinal injections billed pursuant to CPT Code 64483, Spine Care's costs on average are less than the $593.84 it receives from Blue Cross Blue Shield.[81] Yet Spine Care bills State Farm – and insists that State Farm is required to pay – $2,879.90, which represents a nearly 500% profit margin for Spine Care. Given the lack of a direct correlation between Spine Care's standard rates and Spine Care's costs, the trial court's insistence that State Farm demonstrate a correlation between the amount of its reductions and Spine Care's costs is illogical and finds no support in the language of Delaware's PIP statute or the authorities on which the trial court relied.

Moreover, even if the trial court's insistence on a direct correlation between the amount of State Farm's reduction and Spine Care's costs were required (and it is not), the record would not support the trial court's entry of a declaratory judgment that "State Farm's practice of applying . . . MPRs" categorically violates Delaware's PIP statute.[82] The trial court held that Spine Care had not satisfied its burden of demonstrating that its standard rates were reasonable.[83] State Farm offered evidence, including the evidence discussed above, that supports its application of MPRs and

[81] A094:19-A095:1.
[82] *See* Trial Court Order at 10.
[83] *Id.* at 5 n.15.

that indicates that they are reasonable. Thus, even if there were not enough evidence to conclude that State Farm's MPRs result in a reasonable payment to Spine Care, there was, at a minimum, a disputed issue of material fact that precluded the entry of summary judgment.[84]

c. ***The Trial Court Incorrectly Ignored the Evidence State Farm Presented.***

The trial court's refusal to consider the fact that State Farm pays Spine Care vastly more than other types of payors for the same spinal injections is inconsistent with *Anticaglia* and *Watson*. Both of those cases recognize that the amount that other payors pay for the same services is relevant to whether the amount that the provider seeks to recover is reasonable.[85] Here, the undisputed record evidence

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[84] *See Shuba v. United Servs. Auto. Ass'n*, 77 A.3d 945, 947 (Del. 2013) ("'When opposing parties make cross motions for summary judgment, neither party's motion will be granted unless no genuine issue of material fact exists and one of the parties is entitled to judgment as a matter of law.'") (quoting *Emmons v. Hartford Underwriters Ins. Co.*, 697 A.2d 742, 745 (Del. 1997)).

[85] *See Anticaglia*, 1992 Del. Super. LEXIS 122, at *8 ("Ultimately, Provident paid Dr. Anticaglia a total of $470 for the surgery, calculated at $200 under CPT code 11421 for excision of the cyst on the right side of the neck, and $270 under CPT code 11422 for removal of the cyst at the nape of the neck. *Although not necessarily controlling on the issue of what is a 'reasonable and customary' fee in the Wilmington, Delaware area, Provident's method of calculating these payments bears some statistical relevance to that issue.*" (emphasis added)); *Watson*, 2003 Del. Super. LEXIS 344, at *15, 22 (concluding that "Plaintiff's initial proffer of the substance of Dr. Ufberg's anticipated testimony," which included an assertion that the charges at issue were "the very same charges paid by the majority of insurance companies with which he deals," was sufficient to create a disputed issue of fact about whether provider's charges were reasonable).

shows that State Farm pays Spine Care several multiples more than what Spine Care receives from other third-party payors for the same services. This is because, unlike virtually every other type of third-party payor, State Farm pays Spine Care for the first injection Spine Care performs at the full amount of Spine Care's standard billing rate.[86] Other types of third-party payors pay substantially less than this amount because they pay Spine Care pursuant to a negotiated fee schedule.[87] Moreover, when State Farm applies the MPRs to the second and subsequent injections performed in a single operative session, it applies the MPRs to Spine Care's full standard rate. When other third-party payors apply MPRs, they pay only a percentage of the much lower negotiated rate that they pay Spine Care for the first injection.[88]

The end result is that State Farm pays vastly more than other third-party payors for the same injections performed by physicians at Spine Care. In one common example – bilateral spinal injections billed to CPT Code 64483 – the undisputed record evidence showed that Spine Care invoiced all of the third-party payors at its standard rate of $1,439.90 for each side, for a total of $2,879.80 billed for the entire operative session. State Farm paid Spine Care the entire $1,439.90 for the first injection, and applied an MPR to reduce by 50% the amount that it paid

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[86] A071:3-16; A158.
[87] *See, e.g.*, A147-58.
[88] *See, e.g.*, A147-58.

Spine Care for the second injection. Thus, in total, State Farm paid Spine Care $2,159.85 for the two injections. As illustrated by the chart below, no other third-party provider paid more than $796.50 for the same injections – just over a third of the amount that State Farm paid. As even Spine Care's own expert witness admitted, the amount that Spine Care receives from other payors is an "important" factor in assessing whether the amount that State Farm pays is reasonable.[89]

Third-Party Payor	Amount Billed	Amount Paid for First Injection	Amount Paid for Second Injection	Total Amount Paid
State Farm	$2,879.90	$1,439.90	$719.95	$2,159.85[90]
BCBS	$2,879.90	Unknown	Unknown	$593.84[91]
Aetna	$2,879.90	$531.00	$265.50	$796.50[92]
Medicare	$2,879.90	$412.80	$206.40	$619.20[93]

The trial court dismissed this evidence because "private health insurers have contractual relationships with Spine Care that require acceptance of reduced payments" and because "a medical provider that elects to accept Medicare payments has a legal obligation to accept Medicare's reduced payments."[94] But the trial court conflated two very different concepts – reductions to Spine Care's standard rates

[89] A046:3-11.
[90] A158.
[91] A152-54. The exemplar bill Spine Care provided from Blue Cross Blue Shield does not break out the specific amount the insurer paid per injection. However, Spine Care's Rule 30(b)(6) designee confirmed that Blue Cross Blue Shield applies the MPR. A086:13-A087:8.
[92] A148-50.
[93] A156.
[94] Trial Court Order at 8.

based on fee schedules that exist as a result of federal law (in the case of Medicare) or negotiated insurance contracts (in the case of in-network providers) and MPRs, which are standard billing reductions in the medical coding and payment industry. MPRs have nothing to do with the negotiated fee schedules that Spine Care agrees to with private insurance companies. In applying MPRs, State Farm is not attempting to avail itself of the same type of reduced fee schedule that private insurance companies are able to negotiate with Spine Care in exchange for access to their large member base. Rather, State Farm applies MPRs on second and successive injections performed in a single operative session to avoid paying more than once for work that is not repeated after the first injection. In other words, MPRs are applied to avoid paying the provider multiple times for work that the provider only performs once. As the National Correct Coding Initiative Policy Manual explains:

> Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of pre-procedure and post-procedure work.[95]

In short, MPRs have nothing to do with the negotiated contracts between providers and payors.[96] They exist in order to prevent the provider from being compensated

[95] A215.

[96] *See, e.g.*, A049:7-11, A051:17-A052:5 (agreeing that the reason MPRs exist has nothing to do with the identity of the payor).

twice for work that is not repeated when two spinal injections are performed in a single operative session.[97]

Spine Care's Rule 30(b)(6) designee confirmed that some of the work that the physicians who are affiliated with Spine Care are required to perform is not repeated when multiple spinal injections are performed as part of a single operative session for the specific injections that are at issue in this case. The preoperative assessment process is completed only once regardless of the number of injections that are performed in the operative session.[98] Nurses perform intravenous access on the patient only once at the beginning of the procedure.[99] Intravenous antibiotics and preoperative medications are administered only once.[100] Spine Care also incurs some fixed costs that are not dependent on the number of injections that are performed in an operative session.[101] Thus, Spine Care provides less services for the second and successive injections it administers in the same operative session. That

[97] *See* A164 ("The justification for paying the provider less for the second injection performed bilaterally is that, while there is some additional work involved when an injection is performed bilaterally (such as the re-draping and re-positioning of the patient), some of the work is not repeated when the injection is performed on the other side of the spine as part of the same operative session."); A166 ("[A]s with bilateral spinal injections, some of the work that is necessary to perform spinal injections at multiple vertebral levels (such as set-up work) is also necessary for the spinal injection at the first level and does not have to be repeated for each additional injection that is performed as part of the same operative session.").

[98] A075:18-22; *see also* A257.

[99] A076:22-A077:4.

[100] A079:3-8.

[101] A082:14-A083:5.

– and not the fact that Spine Care has contracted for negotiated rates with some private insurance companies – is the reason that State Farm and other third-party payors apply MPRs when multiple procedures are performed in a single operative session.

d. The Trial Court Conflated Medicare Reimbursement Rates and the MPRs

In rejecting State Farm's evidence and arguments supporting its rationale for applying MPRs, the trial court made a critical mistake by conflating Medicare rates with the Medicare Claims Processing Guidelines. State Farm is not attempting to pay Spine Care what Medicare pays Spine Care, or pay any other discounted rate. As explained by State Farm's expert, while CMS created the Medicare's Claims Processing Guidelines, they are widely used as a leading manual for how to bill and how to pay; payors that follow them are in no way paying Medicare rates.[102] In fact, it is undisputed that State Farm pays Spine Care its full standard rates, which is several times more than what Medicare pays.

Nevertheless, Spine Care successfully confused the trial court despite State Farm repeatedly clarifying this issue in its briefing and at oral argument.[103] In its order, the trial court twice describes Spine Care's claim as challenging State Farm's

[102] Deposition of Toni M. Elhoms at 116:2-117:4; 143:10-145:6.
[103] *See, e.g.*, A308-09, A311 ("State Farm's application of MPRs is not an attempt to discount and pay less than Spine Care's standard rate."); A386:6-9; A392:12-23; A405:21-A407:1.

"practice of capping its payments at the Medicare reimbursement rate."[104] Then, in concluding that it was unreasonable for State Farm to apply the Medicare Guidelines, the trial court again conflated the issues, stating that providers that elect to accept Medicare have "a legal obligation to accept Medicare's reduced payments" citing and quoting from a case explaining "Medicare pays, on average, less than one-third of a patient's medical expenses."[105]

e. The Trial Court's Holding Undermines the Purpose of Delaware's PIP Statute.

The trial court's holding should also be reversed because it is inconsistent with the purpose of Delaware's PIP statute, which "'is to protect and compensate all persons injured in automobile accidents.'"[106] Delaware requires owners of motor vehicles to maintain at least $15,000 per person/$30,000 per accident in PIP coverage.[107] This coverage is designed to help a victim of an automobile accident cover a wide variety of expenses, including medical bills, hospital bills, dental bills,

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[104] Trial Court Order at 2, 4.

[105] *See, e.g.*, Trial Court Order at 7-8 & n.30.

[106] *Universal Underwriters Ins. Co. v. Travelers Ins. Co.*, 669 A.2d 45, 48 (Del. 1995) (quoting *Hudson v. State Farm Mut. Ins. Co.*, 569 A.2d 1168, 1171 (Del. 1990).

[107] 21 *Del. C.* § 2118(a)(2)(b).

surgical bills, professional nursing services, and lost earnings.[108] Once the PIP coverage is exhausted, no additional expenses are covered.[109]

PIP insureds benefit – and the purpose of the PIP statute is enhanced – when insureds' PIP coverage is conserved and utilized for as much covered expenses as possible. Spine Care's insistence on receiving the full amount of its standard payment for the second and successive spinal injections performed as part of a single operative session, even while Spine Care realizes cost savings as compared to performing those exact same injections across multiple operative sessions, creates a windfall to Spine Care to the detriment of Delaware's insureds – the very individuals Delaware's PIP statute is intended to protect. This absurd result further illustrates why Spine Care has not carried its burden of demonstrating that its refusal to accept the MPRs is reasonable as a matter of law.

3. Even If State Farm Had the Burden of Demonstrating the Reasonableness of the MPRs, State Farm Was Entitled to Summary Judgment Because it Satisfied that Burden.

As set forth above, Spine Care bears the burden of demonstrating that State Farm's application of MPRs is unreasonable as a matter of law, and Spine Care has

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[108] *Id.* § 2118(a)(2)(a)(1)-(4).
[109] *See Mason v. State Farm Mut. Auto. Ins. Co.*, 1997 Del. Super. LEXIS 270, at *9 (Del. Super. Ct. July 21, 1997) ("PIP coverage meeting the statutory requirements was available to Mason and paid out to the limits of the coverage as required under section 2118(a).").

failed to satisfy that burden. That alone requires reversal of the trial court's decision and the entry of summary judgment in State Farm's favor.

If this Court were to conclude that the trial court was correct that State Farm bears the burden of establishing that its MPRs are reasonable, this Court should nevertheless reverse the trial court's grant of summary judgment to Spine Care and should enter summary judgment in State Farm's favor, even if it were to conclude that Spine Care's insistence on full payment is also reasonable. Indeed, as the Superior Court has recognized, "[t]he words 'reasonable and necessary' qualify the scope of benefits the insurance company must pay," not the maximum amount that a provider is authorized to charge.[110] Thus, Delaware's PIP statute "has been interpreted as 'fixing a statutory minimum rather than a maximum standard of protection.'"[111] This means that, so long as the amount that State Farm pays is

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[110] *See Murphy*, 2005 Del. Super. LEXIS 159, at *10.

[111] *See id.* (quoting *Casson v. Nationwide Ins. Co.*, 455 A.2d 361, 366 (Del. Super. Ct. 1982)); *see also Innovating Phys. Therapy, Inc. v. MetLife Auto & Home*, 2008 U.S. Dist. LEXIS 69377, at *29-30 (D.N.J. Aug. 26, 2008) (rejecting class certification of a challenge to an insurer's reductions under a PIP statute because "[i]f *the amounts Plaintiffs received from Defendants* are 'reasonable,' regardless of how the reimbursements were calculated, then there is no breach of the policy" and no violation of the PIP statute because "PIP statutes address . . .what amounts insurers are obligated to pay") (emphasis added)); *State Farm Mut. Auto. Ins. Co. v. Sestile*, 821 So. 2d 1244, 1246 (Fla. Dist. Ct. App. 2002) ("If an insurer refuses to pay medical expenses that an insured believes are reasonable, the insured may sue, but he or she bears the burden of establishing that the charges are, in fact, reasonable.").

reasonable, Spine Care is not entitled to a larger fee, even if that larger fee is also reasonable.

For all of the reasons set forth above, State Farm's application of MPRs to bilateral and multilevel injections performed in a single operative session is reasonable. Moreover, as Ronda Andrews-Heckman, a claims team manager at State Farm, explained, the MPRs come from the "CPT coding descriptions and their instructions as well as the Medicare Claims Processing Guidelines established by the Center for Medicare Services" because "the guidelines provide consistent, uniform standards for providers and insurers to apply in billing and reimbursing medical services," because the multiple and bilateral procedure reductions are "generally accepted in the medical community and . . . provide[] support for a determination of reasonable charges for necessary medical services."[112] Finally, as discussed above, Delaware insureds also benefit from State Farm's decision to apply MPRs because, "[i]f the separate charges were to be paid in full, without application of the reduction[s], the provider would be paid multiple times for the same services, which would also unnecessarily deplete the insureds of available No-Fault benefits."[113] In short, State Farm's application of the MPRs is reasonable and is fully compliant with Delaware law.

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[112] A302-03 ¶¶ 3, 5, 7.
[113] A302-03 ¶ 5, 7.

CONCLUSION

For all of the foregoing reasons, the trial court erred in granting summary judgment to Spine Care. The trial court incorrectly placed the burden on State Farm to establish the reasonableness of applying the MPRs, and then erred in wholesale rejecting State Farm's undisputed evidence supporting their application. The trial court granted summary judgment to Spine Care without any evidence showing that State Farm's payments were unreasonable in violation of 21 *Del. C.* § 2118.

Spine Care's insistence on receiving the full amount of its standard rate for the second and successive spinal injections performed in a single operative session is unreasonable as a matter of law. It effectively seeks to rewrite Delaware's PIP statute to create a duty to pay any amount a provider wishes to charge, no matter how unreasonable and inequitable as compared to what the provider accepts from other payors, and no matter how harmful to the interests of the insured. 21 *Del. C.* § 2118 does not require this, and it certainly does not prohibit PIP insurers from relying on widely accepted and industry standard claims processing Guidelines to apply MPRs and avoid paying multiple times for services provided only once in bilateral and multilevel injections.

State Farm respectfully requests that this Court reverse the trial court's grant of summary judgment to Spine Care and remand with instructions to enter summary judgment in State Farm's favor.

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