IN THE SUPREME COURT OF THE STATE OF DELAWARE

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

APPELLEE'S ANSWERING BRIEF

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February 17, 2020

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NATURE OF PROCEEDINGS

Plaintiff-below/appellee Spine Care Delaware, LLC ("SCD") commenced this action for declaratory judgment in July 2018. SCD sought a judicial declaration that reductions in payment imposed by State Farm against SCD's PIP-related medical bills — reductions based not on any established criteria under Delaware law, but merely "piggybacked" from Medicare regulations that in no way reflect the going rate in the private health care marketplace — are improper and unlawful under the PIP statute. *Cf. Stayton v. Delaware Health Corp.*, 117 A.3d 521, 524 (Del. 2015) (recognizing that "Medicare pays, on average, less than one-third of a patient's medical expenses.")

The genesis of this lawsuit is unique, and its uniqueness has important consequences for this appeal. Specifically, the parties worked cooperatively in advance of the lawsuit to frame the dispute, and "tee it up" for declaratory judgment, by stipulation.[1] The clear and objective intent was that this case would serve as a referendum on the lawfulness of State Farm's so-called MPRs. The stipulation thus provided that:

[1] B1-3 ("Stipulation for Use in Declaratory Judgment Action"). This stipulation was part of the record below; it appeared as Exhibit C to SCD's opening brief in support of its cross-motion for summary judgment, and was cited at some length in the briefing.

Spine Care Delaware, LLC and State [Farm] Mutual Automobile Insurance Company and State Farm Fire and Casualty Company stipulate to the following facts set forth below, and to the joint filing and use of this Stipulation by the Parties and the Court in the Declaratory Judgment Action:

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9. SCD submits PIP-related bills to State Farm charging 100% for all procedures performed in the same operative session. In paying these bills, State Farm applies the Medicare Claim Processing Guidelines in its reimbursements to SCD for bilateral spinal procedures and spinal procedures performed at multiple vertebral levels in the same operative session.

10. It is SCD's position that Delaware PIP law does not permit State Farm to apply the Medicare reductions in paying PIP claims, and that State Farm must reimburse SCD for 100% of any reasonable fee charged for otherwise covered PIP-related medical bills.

***

12. It is State Farm's position that payment of SCD's bills in accordance with Medicare guidelines provides "compensation to injured persons for reasonable and necessary expenses" in a manner consistent with the requirements of 21 *Del. C.* § 2118(a)(2).

***

15. SCD continues to perform bilateral spinal injections and spinal injections at multiple vertebral levels and to bill State Farm in the manner set forth above. State Farm continues to reimburse SCD in the manner set forth above. Thus, there is ***an ongoing controversy*** between SCD and State Farm with respect to ***whether State Farm is entitled to the reductions*** described above.[2]

[2] B1-2 (emphasis added).

Accordingly, State Farm's complaint about the Superior Court's alleged "burden shifting" is not only misguided; it is a breach of the stipulation by which the issue below was framed. By agreement and design, the case has always been about the propriety of State Farm's reductions.

On summary judgment below, several crucial facts were undisputed, and those facts naturally remain undisputed on appeal. For example, it is undisputed that SCD's fees for bilateral and multilevel procedures are "comparable to those of its two New Castle County competitors." *Spine Care Delaware, LLC v. State Farm Mut. Auto. Ins. Co.*, 2019 WL 5581441, Op. at *1 (Oct. 29, 2019) (the "Superior Court Opinion"). It is undisputed that, since SCD's inception in 2000, other Delaware PIP insurers — including Nationwide, Allstate, Geico, Liberty Mutual, Progressive, Selective, Farmers, Travelers, Hartford and others — have routinely paid the full amount of SCD's fees for bilateral and multilevel spinal injections, ***without*** applying so-called MPRs.[3] It is undisputed that, despite its litigation posture, ***State Farm itself*** has repeatedly paid "full freight" for such procedures, thereby acknowledging the reasonableness of the amounts billed by SCD for a second vertebral side or additional vertebral levels (and, by extension, the impropriety of the disputed MPRs).[4] And it is undisputed that SCD's per-case

[3] B221-22.

[4] B222-23.

revenues are well below the high end for ambulatory surgical centers in the field of pain management, and quite close to the nationwide median — a circumstance that could not logically exist if SCD were routinely overcharging PIP carriers (or, indeed, any carriers).[5]

Though State Farm asks in the alternative that this Court find a genuine issue of material fact, State Farm agreed at oral argument below that "there is no genuine issue of material fact and . . . this matter [was] ripe for decision on the merits based upon the record before [the Superior Court]." Superior Court Opinion at *3.

On October 29, 2019, the Superior Court granted SCD's summary judgment motion and denied State Farm's summary judgment motion. The Superior Court thus issued a judicial declaration to the following effect:

> (1) State Farm must pay Spine Care for any reasonable amount charged by Spine Care for covered, PIP-related medical expenses; and
>
> (2) 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).

Superior Court Opinion at *5.

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[5] B223. *See also* https://avanzastrategies.com/wpcontent/uploads/2014/05/Avanza-_ASC_Benchmarks_2017.pdf (last visited on February 11, 2020) (compiling data on per-case revenues for pain management specialty); https://vmghealth.com/wp-content/uploads/2018/01/VMG-Health-Intellimarker-Multi-Specialty-ASC-Study-2017.pdf, at 22 (last visited on February 11, 2020) (same).

SUMMARY OF ARGUMENT

1. Denied. The Superior Court properly granted summary judgment to SCD, and properly denied summary judgment to State Farm.

First, the parties stipulated, in advance of this lawsuit, that this case would essentially be a referendum on the propriety of State Farm's application of Medicare-prescribed reductions to SCD's bills for bilateral and multilevel procedures. By resolving the controversy that was framed by the parties' stipulation, the Superior Court acted properly. Indeed, it would have been improper for the Superior Court to do otherwise. Stated differently, this was not improper "burden shifting"; it was simply a matter of the Superior Court's resolving the dispute that both sides brought to the courthouse for resolution.

Second, by requiring State Farm to support its Medicare reductions on covered bills, the Superior Court imposed no burden on State Farm that did not already exist under settled law. After all, medical bills to which State Farm applies its Medicare reductions are, by definition, covered bills for purposes of PIP — the dispute on such bills being not ***whether*** State Farm will pay, but ***how much*** it will pay. Under settled law, when an insurer pays a reduced amount on a covered medical bill, it must have a reasonable basis for the reduction. *See Tackett v. State Farm Fire & Cas. Ins. Co*., 653 A.2d 254, 264 (Del. 1995) (implied duty of good faith and fair dealing requires that denials of coverage, whether in whole or part, be

supported by a reasonable basis). And under the PIP statute, a carrier that pays less than the full amount of a provider's bill must explain its position. *See* 21 *Del. C.* § 2118B(c) (requiring insurers to explain partial denials in writing within 30 days of receipt of the provider's bill). Accordingly, both *Tackett* and section 2118B impose a burden on State Farm to support its use of Medicare reductions. To impose a burden on the provider to explain why its ***already covered*** bill should be paid in full would turn the law on its head.

Third, the undisputed record shows that (i) SCD's fees for bilateral and multilevel procedures are comparable to those of its two New Castle County competitors; (ii) since SCD's inception in 2000, a host of Delaware PIP insurers have routinely paid the full amount of SCD's fees for bilateral and multilevel spinal injections, without applying Medicare reductions; (iii) State Farm itself has repeatedly paid the full amount of such fees, likewise without applying Medicare reductions; and (iv) SCD's per-case revenues are quite reasonable. On this record, State Farm clearly bore an evidentiary burden to show that its use of Medicare reductions results in reasonable compensation to SCD. But though State Farm purports to justify its use of the reductions based on SCD's duplication of services, it never showed — indeed, it never even attempted to show — how its reduced payments correlate to any duplicated service.

Fourth, though State Farm claims to have shown that Medicare reductions are widely used in "the medical billing and payment industry," nothing in the record suggests that such an "industry" even exists. What indisputably ***does*** exist is the auto insurance industry; and again, the undisputed record confirms that Delaware PIP carriers, including Nationwide, Allstate, Geico, Liberty Mutual, Progressive, Selective, Farmers, Travelers, Hartford and others (and often including State Farm itself) routinely pay the full amount billed by SCD for bilateral and multilevel procedures, without applying Medicare reductions.

Finally, not only are there no genuine issues of material fact to support a reversal of the Superior Court's ruling, but State Farm actually agreed, at oral argument below, that no such issues exist. For all these reasons, the Superior Court's decision should be affirmed.

STATEMENT OF FACTS

A. About SCD

Plaintiff Spine Care Delaware, LLC is an ambulatory surgical center (or "ASC") located in Newark, Delaware. Its practice focuses on minimally invasive spinal injections. However, SCD is best understood as a facility — specifically, a state-of-the-art facility where Delaware surgeons, who are independent of SCD, come to treat patients. Often, those patients have been injured in auto accidents.

Being a surgical facility, SCD charges a facility fee for each operative session.[6] The facility fee is a broadly inclusive charge; it encompasses everything from preoperative phone calls, patient registration and history, patient physicals, medications, medical supplies, postoperative care, registered nurses, x-ray technicians and medical technicians, other staffing, fixed expenses and overhead, and so forth.[7]

By way of example, the procedures performed at SCD include cervical and lumbar epidurals, cervical and lumbar selective nerve root blocks, cervical and lumbar facet joint nerve blocks, cervical and lumbar facet joint nerve ablations,

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[6] B48. The cited matter is from the transcript of deposition of Bonnie O'Connor. Ms. O'Connor, who was deposed in her capacity as SCD's designee under Superior Court Civil Rule 30(b)(6), is a licensed Orthopedic Physician Assistant, and Administrator of SCD. B34, B37, B39.

[7] B48. Because the surgeons are independent of SCD, they bill separately and independently of SCD. SCD thus does not handle physician billing. B50.

and cervical, lumbar, and thoracic discographies.[8] Based on recent patient surveys, SCD has a 98% patient satisfaction rating.[9]

As State Farm correctly notes, SCD bills according to CPT Codes. These are the widely recognized billing codes for "Current Procedural Terminology," copyrighted by the American Medical Association and (according to the AMA) "the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs."[10]

B. The Stipulated Facts

In anticipation of this lawsuit, the parties stipulated to certain facts, and to the use of the stipulation by the Court and parties. These stipulated facts include:

> 1. [SCD] is an Ambulatory Surgical Center ("ASC") that focuses exclusively on minimally invasive spinal injections. ***
>
> ***
>
> 5. SCD patients include Delaware insureds who have purchased PIP coverage from State Farm . . . . Some of the State Farm Patient-Insureds that SCD treats receive bilateral spinal injections (i.e., spinal injections performed on both sides of the spine) and/or spinal injections performed at multiple vertebral levels.
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> ***

[8] B221.

[9] *Id.*

[10] Https://www.ama-assn.org/practice-management/cpt-purpose-mission (last visited on February 11, 2020).

9. SCD submits PIP-related bills to State Farm charging 100% for all procedures performed in the same operative session. In paying these bills, State Farm applies the Medicare Claim Processing Guidelines in its reimbursements to SCD for bilateral spinal procedures and spinal procedures performed at multiple vertebral levels in the same operative session.

10. It is SCD's position that Delaware PIP law does not permit State Farm to apply the Medicare reductions in paying PIP claims, and that State Farm must reimburse SCD for 100% of any reasonable fee charged for otherwise covered PIP-related medical bills.

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12. It is State Farm's position that payment of SCD's bills in accordance with Medicare guidelines provides "compensation to injured persons for reasonable and necessary expenses" in a manner consistent with the requirements of 21 *Del. C.* § 2118(a)(2).

***

15. SCD continues to perform bilateral spinal injections and spinal injections at multiple vertebral levels and to bill State Farm in the manner set forth above. State Farm continues to reimburse SCD in the manner set forth above. Thus, there is an ongoing controversy between SCD and State Farm with respect to whether State Farm is entitled to the reductions described above.[11]

[11] B1-2.

C. SCD's Competitors and Their Facility Fees

The Superior Court noted, and State Farm does not dispute, that SCD's facility fees for bilateral and multilevel procedures are "comparable to those of its two New Castle County competitors." Superior Court Opinion at *1. On this undisputed record, State Farm cannot credibly argue that SCD's fees for such procedures are excessive, or that SCD is in any way an outlier.

D. The Undisputed Payment Habits of PIP Insurers Generally

There is no dispute that, since SCD's inception in 2000, other Delaware PIP insurers — including Nationwide, Allstate, Geico, Liberty Mutual, Progressive, Selective, Farmers, Travelers, Hartford and others — have routinely paid the full amount of SCD's fees for bilateral and multilevel spinal injections.[12]

E. State Farm's Inconsistent and Contradictory Payment Habits

Despite State Farm's litigation posture, the company has been unable to get its adjusters to stick to the script. Precisely because State Farm's Medicare reductions are arbitrary and insupportable, State Farm's adjusters have paid SCD the full amount charged for bilateral and multilevel procedures again and again.[13] This is undisputed.

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[12] B221-22.

[13] B222-23.

F. The Benchmarking Data

The record below included benchmarking reports from Avanza Healthcare Strategies and VMG Health. Avanza is a consultancy that provides financial and regulatory services to health care providers.[14] VMG provides valuation and other services to the health care industry.[15] SCD's medical billing expert testified by affidavit that these benchmarking products are of a type on which experts in the field of medical billing rely.[16]

The Avanza report compiles 2017 revenue data, on a per-case basis, for ASCs in a variety of disciplines. For ASCs that (like SCD) provide pain management services, the report shows per-case revenues for 2017 of $770 at the low end, and $2,169 at the high end.[17] For this same category of ASCs, the VMG report shows median 2017 per-case revenues of $1,074.[18] By contrast, SCD's 2017

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[14] *See* https://avanzastrategies.com/about/ (last visited on February 11, 2020).

[15] *See* https://vmghealth.com/about-us/ (last visited on February 11, 2020).

[16] B230.

[17] *See* https://avanzastrategies.com/wpcontent/uploads/2014/05/Avanza-_ASC_Benchmarks_2017.pdf (last visited on February 11, 2020).

[18] *See* https://vmghealth.com/wp-content/uploads/2018/01/VMG-Health-Intellimarker-Multi-Specialty-ASC-Study-2017.pdf, at 22 (last visited on February 11, 2020).

per-case revenue was $1,099.24 — well below the high end for pain management ASCs, and quite close to the nationwide median.[19]

G. SCD's Modest Fee Increases

Since SCD's inception in 2000, it has increased its fees just four times. None of these increases exceeded the consumer price index.[20] Indeed, SCD has increased fees just once since 2015 — but again, no more than required to keep pace with the CPI.[21]

H. The Sketchy and Obscure History of State Farm's Adoption of Medicare Reductions

SCD has approached this dispute with perfect transparency. SCD's Rule 30(b)(6) designee, Ms. O'Connor, testified in detail regarding the nature of the medical procedures performed at SCD; the "mechanics" of those procedures; SCD's billing practices; the goods and services encompassed by its facility fee; the payment habits of various private insurers that reimburse SCD; the CPT Codes employed by SCD for billing purposes, and so forth.[22] But what of State Farm?

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[19] B223.

[20] B223.

[21] B223-24.

[22] B48-53, B57-59, B88-97, B114, B117-23.

State Farm says that it began "piggybacking" on Medicare reductions for bilateral and multilevel procedures in 2005.[23] Yet the company did not begin imposing those reductions on SCD until roughly 5 years ago.[24] As to the nearly decade-long delay, State Farm has no explanation. Remarkably, State Farm claims to be unable to identify ***even a single document*** relating to its adoption of Medicare reductions.[25] The nation's largest auto insurer, largest homeowners insurer, and second-largest health insurer — a company that ranks 36th on the Fortune 100 — thus has no documentary record whatever of the decision-making process (if any) by which it decided to impose hundreds and even thousands of dollars in reimbursement reductions, on a per-medical-bill basis, under the Delaware PIP statute.[26]

[23] B7-8.

[24] B224.

[25] B8-9.

[26] *See* financial information at https://newsroom.statefarm.com/numbers-behind-the-neighbors/ (last visited on February 11, 2020).

ARGUMENT

I. BY RESOLVING THE CONTROVERSY THAT THE PARTIES FRAMED BY THEIR STIPULATION, AND THAT STATE FARM FRAMED BY ITS SUMMARY JUDGMENT MOTION, THE SUPERIOR COURT ACTED PROPERLY

A. Question Presented

Did the Superior Court act properly when it resolved the question that the parties expressly "teed up" for declaratory judgment, and State Farm expressly framed by its summary judgment motion? (Preserved at pages B1-3, B237, and B271-72 of the accompanying appendix.)

B. Scope of Review

This Court reviews the Superior Court's decision on a motion for summary judgment *de novo*. *GMG Capital Invs., LLC v. Athenian Venture Partners I, L.P.*, 36 A.3d 776, 779 (Del. 2012); *Paul v. Deloitte & Touche, LLP*, 974 A.2d 140, 145 (Del. 2009). Questions of contract interpretation are likewise reviewed *de novo*. *GMG Capital*, 36 A.3d at 779 (citing, *inter alia*, *Paul*, 974 A.2d at 145).

C. Merits of the Argument

The basic thrust of State Farm's appeal is that the Superior Court was wrong to decide the very question State Farm asked it to decide. That question was framed, in unmistakably clear language, first in the pre-litigation agreement that "teed up" the case for declaratory judgment, and again in State Farm's own summary judgment motion.

As noted above, the parties' pre-litigation *Stipulation for Use in Declaratory Judgment Action* — a binding, written contract — framed the parties' dispute with precision. Paragraph 10 set forth SCD's position: that Delaware law "does not permit State Farm to apply the Medicare reductions in paying PIP claims . . . ." Paragraph 12 set forth State Farm's position: that its imposition of Medicare reductions is "consistent with the requirements of 21 *Del. C.* § 2118(a)(2)." Paragraph 15 defined the exact controversy that the parties agreed to place before the Superior Court:

> 15. SCD continues to perform bilateral spinal injections and spinal injections at multiple vertebral levels and to bill State Farm in the manner set forth above. State Farm continues to reimburse SCD in the manner set forth above. Thus, there is an ongoing controversy between SCD and State Farm with respect to whether State Farm is entitled to the reductions described above.[27]

State Farm's summary judgment motion defined the controversy, and the motion itself, in the very same terms. Specifically, though State Farm's one-page motion did not state the grounds for the motion, it did refer the Superior Court to State Farm's opening brief below: "The grounds that entitle State Farm to summary judgment and a declaratory judgment in its favor are fully set forth in the brief filed herewith, and will be further presented at oral argument on this motion, which has

[27] B2.

been set for August 16, 2019 at 11:00 a.m."[28] Consistent with this statement, State Farm's opening brief succinctly stated the issue on summary judgment :

> This is a declaratory judgment action raising a single straightforward question: Does Delaware's Personal Injury Protection ("PIP") statute prohibit insurers like State Farm from applying bilateral and multiple procedure payment reductions ("MPRs") when reimbursing providers for spinal injections performed bilaterally or at multiple vertebral levels?[29]

The record is thus clear. State Farm agreed, in a binding written instrument, that the propriety of its application of Medicare reductions would be decided by way of a declaratory judgment action to be commenced by SCD.[30] Ultimately, State Farm moved for summary judgment on that very question, framing not just its motion ***but the lawsuit itself*** as a referendum on its imposition of Medicare reductions. For State Farm to argue that the Superior Court acted improperly by resolving the very question State Farm asked it to resolve is at once a violation of the parties' pre-litigation agreement, and a betrayal of State Farm's representations to the Superior Court (that is, that the propriety of the company's imposition of Medicare reductions was the single, straightforward question presented both by the lawsuit and State Farm's motion).

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[28] B231.

[29] B237.

[30] B1-3.

In short, the Superior Court did not engage in any improper "burden shifting." It merely answered the single, straightforward question that State Farm asked it to answer. Though State Farm is clearly unhappy with that answer, its disaffection does not constitute legal error.

II. THE SUPERIOR COURT IMPOSED NO BURDEN ON STATE FARM THAT DID NOT ALREADY EXIST UNDER SETTLED LAW

A. Question Presented

By requiring State Farm to support its reductions on admittedly covered PIP bills, did the Superior Court subject State Farm to some form of extralegal burden, where settled law requires that (i) State Farm must have a reasonable, articulable basis to justify such reductions, and (ii) State Farm must affirmatively explain such reductions? (Preserved at pages A120-35 and A311-12 of State Farm's appendix.)

B. Scope of Review

This Court reviews the Superior Court's decision on a motion for summary judgment *de novo*. *GMG Capital Invs., LLC v. Athenian Venture Partners I, L.P.*, 36 A.3d 776, 779 (Del. 2012); *Paul v. Deloitte & Touche, LLP*, 974 A.2d 140, 145 (Del. 2009).

C. Merits of the Argument

By definition, medical bills to which State Farm applies Medicare reductions are covered bills for purposes of PIP — the dispute on such bills being not ***whether*** State Farm will pay, but ***how much*** it will pay. Under settled law, when an insurer pays a reduced amount on a covered bill, it must have a reasonable, articulable basis for the reduction. *See Tackett v. State Farm Fire & Cas. Ins. Co.*, 653 A.2d 254, 264 (Del. 1995) (implied duty of good faith and fair dealing requires that

denials of coverage, whether in whole or part, be supported by a reasonable basis). In addition, the PIP statute requires that when a carrier pays less than the full amount of a provider's bill, it must explain its position:

> When an insurer receives a written request for payment of a claim for benefits pursuant to § 2118(a)(2) of this title, the insurer shall promptly process the claim and shall, no later than 30 days following the insurer's receipt of said written request for first-party insurance benefits and documentation that the treatment or expense is compensable pursuant to § 2118(a) of this title, make payment of the amount of claimed benefits that are due to the claimant or, ***if said claim is wholly or partly denied***, provide the claimant ***with a written explanation of the reasons*** for such denial.

21 *Del. C.* § 2118B(c) (emphasis added).

Importantly, PIP is no ordinary insurance product. This Court has recognized that the purpose of Delaware's statutory PIP scheme "is to remove the expense and uncertainty of automobile accident litigation, allowing the insured to receive prompt payment for medical expenses and lost wages regardless of who was at fault." *Selective Ins. Co. v. Lyons*, 681 A.2d 1021, 1024 (Del. 1996). Section 2118B's express purpose is:

> [T]o ensure reasonably prompt processing and payment of sums owed by insurers to their policyholders and other persons covered by their policies . . . and to prevent the financial hardship and damage to personal credit ratings that can result from the unjustifiable delays of such payments.

21 *Del. C.* § 2118B(a). Where PIP is concerned, then, speed is fundamental. It is thus not the case that when a provider submits a covered, PIP-related medical bill

to State Farm, accompanied by the required medical documentation (which is part of what makes the bill covered in the first place), the provider also provides State Farm with an affidavit attesting to the reasonableness of the dollar amount charged — any more than a law firm's bill for legal services would be accompanied by such proofs. Rather, the medical documentation submitted with the provider's invoice serves to support the dollar amount charged. If State Farm then makes only partial payment (as is the case with its Medicare reductions), both *Tackett* and section 2118B impose a burden on State Farm to support its position. To impose a burden on the provider to explain why its ***already covered and supported*** bill should be paid in full would turn the law on its head.

III. BECAUSE STATE FARM NEVER EVEN ATTEMPTED TO CORRELATE ITS HEFTY REDUCTIONS TO ANY PARTICULAR, DUPLICATIVE SERVICE, THE SUPERIOR COURT CORRECTLY FOUND THAT ITS ARGUMENTS FAILED AS A MATTER OF LAW

A. Question Presented

Does State Farm's position fail as a matter of law, where the company made no effort to correlate its Medicare reductions to any allegedly duplicative service? (Preserved at pages B288-91 and B331-34 of the accompanying appendix.)

B. Scope of Review

This Court reviews the Superior Court's decision on a motion for summary judgment *de novo*. *GMG Capital Invs., LLC v. Athenian Venture Partners I, L.P.*, 36 A.3d 776, 779 (Del. 2012); *Paul v. Deloitte & Touche, LLP*, 974 A.2d 140, 145 (Del. 2009).

C. Merits of the Argument

The Superior Court found that:

> State Farm has failed to 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, or how the MPR-modified bills conform to the specific factors listed in *Anticaglia* and *Watson.* In other words, State Farm's MPR calculations fail to show that they are logically or consistently related to what reasonable fees should be, pursuant to the *Anticaglia* and *Watson* factors, for the procedures performed by Spine Care.

Superior Court Opinion at *4 (citing *Anticaglia v. Lynch*, 1992 WL 138983 (Del. Super. Ct. March 16, 1992) and *Watson v. Metro Prop. & Cas. Ins. Co.*, 2003 WL 22290906 (Del. Super. Ct. Oct. 2, 2003)). The Superior Court thus recognized the arbitrary nature of State Farm's MPR regime as applied to SCD's services.

State Farm's only response is that, despite its pre-litigation agreement to litigate the merits of its Medicare reductions by way of declaratory judgment; despite its motion below, specifically asking the Superior Court to rule on the merits of its Medicare reductions; and despite the clear requirements of *Tackett* and section 2118B(c), which affirmatively require State Farm to explain and support its Medicare reductions — despite all this, State Farm cannot properly be called upon to correlate the reductions to reality. For the reasons explained above, that claim of procedural grievance should be rejected. But what of the merits?

To appreciate the consequences of State Farm's failure to correlate its reductions to particular, duplicative services, it is helpful to first consider the PIP statute's "reasonableness" standard itself; and from there, to consider State Farm's default on the issue.

i. "Reasonableness" Under the PIP Statute

The PIP statute sets forth no definition of the term "reasonable" as applied to the dollar amount of medical bills. However, the Superior Court has long recognized that the chief indicium of the reasonableness of medical fees is the dollar amount charged by other medical professionals in the locality for the same services.

The first of these cases was *Gen'l Motors Corp. v. English*, 1991 WL 89812 (Del. Super. Ct. May 10, 1991). In *English*, General Motors (which was self-insured for workers' compensation) challenged the reasonableness of fees charged by the injured worker's orthopedic surgeons.[31] General Motors argued that, because the orthopedic practice accepted lesser payment from private health insurers with whom the practice had contracted, General Motors was entitled to pay this lesser amount, rather than the amount billed:

> The primary dispute in this case is the dual nature of Wilmington Orthopaedic's billing system — the disparity between charges in workmen's compensation cases and charges for similar services in noncompensation cases. Wilmington Orthopaedic does not always collect full payment for fees charged for medical services rendered because it has contractual agreements with six insurance carriers. In these agreements, Wilmington Orthopaedic accepts as full payment a predetermined amount set by the carrier, which is often less than the

[31] *English* was decided long before the 2008 amendments to the workers' compensation statute. Those amendments adopted a fee schedule for workers'-compensation-related medical expenses. That is why it was necessary (in 1991) for the Delaware Industrial Accident Board, and eventually the Superior Court, to resolve a dispute surrounding the reasonableness of fees for orthopedic care.

> standard amount Wilmington Orthopaedic charges for a particular procedure. In consideration, Wilmington Orthopaedic receives a continuous flow of patients, prompt payments and administrative ease. Wilmington Orthopaedic does not have such a contract with GM.
>
> In response to this system, GM identifies charges for medical procedures in workmen's compensation cases that might be significantly higher than if the bill had been for a noncompensation case. GM then pays the provider of services the sum that would have been charged for the same procedure in a noncompensation case, contending that the lesser amount is a "reasonable" fee.
>
> ***
>
> GM argues that the term "reasonable cost" should be construed to mean a community standard, that is, an amount regularly charged for similar medical services in the community.

English, Op. at *1-2.[32] The Superior Court found GM's argument to be "without merit." *English*, Op. at *2. Instead of measuring the reasonableness of the orthopedic practice's fees against the dollar amounts paid by private health insurers under contract — contracts by which those insurers conferred valuable consideration on providers — the Superior Court looked to the fees charged by other orthopedic surgeons in the locality for the same treatment:

> All medical evidence presented by other orthopedic surgeons indicates that the fees charged by Wilmington Orthopaedic were reasonable and within the range of fees charged for the types of treatment rendered. The only evidence that GM presented to rebut ***the presumption of reasonableness in favor of claimant*** was that Wilmington Orthopaedic accepts a smaller payment from contract carriers. GM

[32] As with the PIP statute here, the worker's compensation statute in *English* set forth no definition of the term "reasonable" in relation to medical expenses. *English*, Op. at *2.

> does not have a contractual relationship with Wilmington Orthopaedic and is not entitled to the status or benefits of a contract to which it is not a party.

Id. (emphasis added).

The Superior Court next decided *Anticaglia v. Lynch*, 1992 WL 138983 (Del. Super. Ct. March 16, 1992). In *Anticaglia*, the task was to once again assess the reasonableness of medical fees "in the absence of a contract" between the provider and the insurer. *Anticaglia*, Mem. Op. at *6. Relying on *English*, the Superior Court identified several relevant factors, looking first and foremost to the fees charged by other providers for the same treatment in the same locality:

> The determination of a reasonable and customary fee is entirely factual in nature. In resolving that issue the Court or jury may take into account 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 for the services rendered.

Anticaglia, Mem. Op. at *6 (citing *English*; other citations omitted). As in *English*, *Anticaglia* explained why the dollar amounts paid by private health insurers under contract are generally an inappropriate yardstick for the reasonableness of medical fees:

> Normally, the rule that precludes such acceptance [of evidence of charges paid under contract] derives from the fact that payments are the result of contractual agreements between the insurer and healthcare providers. Thus, they might not bear any statistical relevance to reasonable and customary charges usually made in the community.

Anticaglia, Mem. Op. at *7.[33] *Anticaglia* thus acknowledged, at least implicitly, that private health insurers pay less under negotiated contracts. But they also bring real value to the table, offering providers access to a large population of patients, and rewarding providers with prompt payment and administrative ease. PIP insurers do not contract with providers, and they bring nothing to the table. What is worse, PIP insurers are notorious for delaying payment and forcing providers to fight for every penny. That is why the General Assembly enacted 21 *Del. C.* § 2118B: to "ensure reasonably prompt processing and payment of sums owed by insurers to their policyholders and other persons covered by their policies pursuant to § 2118 of this title, and to prevent the financial hardship and damage to personal credit ratings that can result from the unjustifiable delays of such payments." 21 *Del. C.* § 2118B(a). SCD's Administrator thus testified by affidavit:

[33] *And cf. Brooks v. Educators Mut. Life Ins. Co*., 206 F.R.D. 96, 98 n.1 (E.D. Pa. 2002) (recognizing that under private health insurance contracts, "an insurance company agrees to refer its insureds to providers in the network in exchange for the providers' agreement to charge the insurance company reduced fees for medical procedures and services.")

> It has been SCD's experience that SCD's billing department is forced to devote an inordinate amount of time and resources to persuading or attempting to persuade auto insurers to make appropriate payment on covered claims. It has likewise been SCD's experience that, despite the Delaware PIP statute's 30-day payment deadline, SCD must wait longer for full and/or final payment from auto insurers than from other types of insurers — significantly longer than, for example, private health insurers.[34]

More recently, in a case addressing the reasonableness of medical fees under the PIP statute, the Superior Court cited with approval the *Anticaglia* factors — including, of course, the single most important factor of "ordinary and reasonable charges usually made by members of the same profession of similar standing for services such as those rendered . . . ." *Watson v. Metro Prop. & Cas. Ins. Co.*, 2003 WL 22290906 (Del. Super. Ct. Oct. 2, 2003), Letter Op. at *5-6 (quoting *Anticaglia* at *6).

While making no effort whatever to address *English*'s discussion of the "presumption of reasonableness" for otherwise covered medical bills, State Farm attempts to distinguish *Anticaglia* and *Watson* on the basis that those cases involved "specific bills." But the company fails to explain the significance of this distinction. Suffice to say that the bills that SCD submits to State Farm are just as tangible and just as real as the bills that were litigated in *Anticaglia* and *Watson.*

[34] B224-25.

In short, the cases are clear. The most logical and important factor in assessing the reasonableness of medical fees under the PIP statute — or wherever the concept of "reasonableness" remains undefined — is data on fees in the same locality for the same or similar treatment.[35] Equally important, a comparison to the dollar amounts negotiated by private health insurers under contract is unhelpful (and thus irrelevant) in such a setting. And Medicare, of course, actually ***dictates*** how much the provider will be paid. *See* Superior Court Opinion at *4 ("[A] medical provider that elects to accept Medicare payments has a legal obligation to accept Medicare's reduced payments.") The crucial factor, then, is undisputed: the Superior Court correctly found that SCD's "facility fee for each medical procedure . . . is comparable to those of its two New Castle County competitors." Superior Court Opinion at *1.

Meanwhile, a close corollary to the "fees charged by other professionals in the same locality" factor is *the amount generally paid by the same class of payors for the same or similar service*. This, too, is undisputed: SCD established below that a host of Delaware PIP carriers pay the full amount charged by SCD for bilateral and multilevel procedures, without imposing Medicare reductions. SCD even established that State Farm itself has repeatedly paid the full amount of SCD's

[35] In assessing the reasonableness of attorneys' fees, Delaware law similarly looks to "the fee customarily charged in the locality for similar . . . services," among other factors. *Mahani v. Edix Media Grp., Inc.*, 935 A.2d 242, 245-46 (Del. 2007).

fees for bilateral and multilevel procedures, without MPRs. This is because State Farm's adjusters, when presented with SCD's fees, recognize them as reasonable. It is only when those adjusters remember (or are reminded by their superiors) that their employer insists on a regime of artificial reductions that State Farm pays less than the full amount.

ii. Maximum vs. Minimum

State Farm offers an out-of-context quote from *Casson v. Nationwide Ins. Co.*, 455 A.2d 361 (Del. Super. Ct. 1982) for the proposition that a PIP carrier need only pay the low end of the range of reasonableness on covered medical bills. But *Casson* says nothing of the kind. Rather, *Casson* merely notes that though the PIP statute establishes the bare minimum of required coverage, insurers are free to offer more coverage if they so desire. Specifically, *Casson* stated:

> Loss of earnings . . . [means] any amounts actually lost, net of taxes on income which would have applied by reason of inability to work and earn wages or salary . . . that would otherwise have been earned in the normal course of an injured person's employment.
>
> ***
>
> This limitation has the effect of requiring that "lost earnings[]" under the statute be reduced by any income from substitute work actually performed by the insured or by income he would have earned in available substitute work he was capable of performing but unreasonably failed to undertake. *** I conclude, therefore, that under Section 2118 the insured does have a duty to mitigate by seeking substitute employment.

> But Section 2118 fixes a statutory minimum rather than a maximum standard of protection[,] and the act expressly permits the issuance of policies providing for more extensive coverages. 21 *Del. C.* § 2118(c).
>
> The P.I.P. endorsement contained in Nationwide's policy states: "We will pay for loss of earnings, meaning employment income actually lost, within two years after the accident, net of taxes, if the bodily injury prevents the insured from working at his normal employment." ***
>
> Here, the language of the policy is free from any ambiguity and is susceptible of only one meaning — the language of the policy has extended the statutory minimum coverage by eliminating the requirement of "necessary" from its provision. As a result[,] the standard of recovery is earnings "actually lost," without qualification. While income from substitute work actually performed might reduce the insured's recovery, there is no affirmative duty on the insured to seek such substitute employment and his entitlement is not conditioned on such effort. This interpretation of policy enlargement finds support in the language of the policy's medical expense clause which, by contrast, retains the statutory language of "reasonable and necessary."

Casson, 455 A.2d at 366 (emphasis in original; internal citations and quotations omitted in part).

In other words, *Casson* addressed a situation in which the PIP carrier's policy language expressly enlarged the scope of coverage for lost earnings, affirmatively providing broader coverage than the minimum coverage required under section 2118. None of this remotely supports State Farm's claim that the PIP statute allows a PIP carrier to construe "reasonable expenses" to mean only the lowest reasonable expense, to the exclusion of reasonable expenses at the high end of the range of reasonableness or the middle of the range of reasonableness.

Indeed, the plain meaning of "reasonable" requires the PIP carrier to pay ***any*** reasonable amount charged, so long as the bill is otherwise covered.

iii. State Farm's Failure to Correlate its Reductions to Reality

State Farm insists that its Medicare reductions are necessary to avoid paying twice for something that should only be charged once. In its opening brief below, State Farm thus argued that "while there is some additional work involved when an injection is performed bilaterally . . . 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."[36] More recently, State Farm has abandoned the qualifier "some" for a stronger, though no less vague, qualifier: at page 8 of its opening brief on this appeal, State Farm now argues that "***much*** of the work is not repeated for each additional injection that is performed."[37] But what would State Farm have this Court do with its repeated refrain about "some" overlap or "much" overlap? The company retained no medical expert, nor any expert of any kind, to put meat on the bone; so it cannot say that *this specific task, valued in the health care marketplace at X dollars, is performed only once*. Moreover, as SCD made clear in its interrogatory responses below, surgery is not a fungible process:

[36] B251-52.

[37] State Farm's opening brief on appeal, at 8 (emphasis added).

The process of completing an injection, whether bilaterally or on multiple levels, varies by patient, by physician, by procedure, and by operative session. The only aspect of the process that is not dependent on the levels, sides, and anatomy occurs during the registration and preoperative assessment of the patient by either the nurse or the Certified Registered Nurse Anesthetist.

*** [D]epending on the procedure, the patient, and the medical history, intravenous antibiotics and preoperative medications are administered.

*** Depending on the physician, the procedure, and the patient's anatomy, needles, probes, IV contrast material, steroids, and anesthetic medication are prepared and placed on the field. *** Depending on the physician's preference, the field is prepped for either the initial injection only, or for multiple injections with separate sterile fields. For example, one physician may prefer to complete the initial injection and then prep the area for the second injection and repeat the procedure. Another physician may prefer to prep the skin area and create multiple sterile areas for injections prior to beginning the procedure.

***

Once the procedure is completed, the patient is transported to SCD's recovery area, and monitored until discharged from the facility. Each patient's recovery is unique; however, the duration of recovery time is typically dependent on the length of the procedure and the amount of anesthesia administered during the procedure.

*** The longer the procedure and/or the recovery, the greater the cost incurred by SCD based on staffing costs alone.[38]

[38] B14-16.

To take but one example, an obese patient generally requires more anesthesia and more operating room time than a patient who is not obese. This is a matter of common sense. And for this reason, there are occasions when a procedure performed on one vertebral side may actually impose greater costs on SCD — including staffing costs, supply costs, and so forth — than does a bilateral procedure. Similarly, a particular patient's unique anatomy can mean that a unilateral procedure requires more time, more anesthesia, and more supplies than does the average bilateral procedure. Yet SCD does not charge a larger fee when a procedure involves more complexity or takes more time. Instead, it charges the same fee for that procedure every time.

In other words, State Farm offered the Superior Court no rational basis to support any reduced payment in any amount. Should the Superior Court have allocated $5 to the patient registration process — which takes place only once — and on that basis, upheld a $5 reduction? Should the Superior Court have allocated $10 to the registration process? Or $50? Or ten cents? How do qualifiers like "some" and "much" (as in "some overlap" or "much overlap") translate into dollars and cents? State Farm cannot say, because it does not know. And because it does not know, the Superior Court correctly rejected its use of Medicare reductions.

IV. THE SUPERIOR COURT'S DECISION IS SUPPORTED BY INDEPENDENT, ALTERNATIVE BASES

A. Question Presented

Should the Superior Court's decision be affirmed where it is supported by independent and alternative bases that were fully presented below? (Preserved at Superior Court Opinion at *1 ("Spine Care charges a facility fee for each medical procedure that is comparable to those of its two New Castle County competitors"); and at pages B273-77 of the accompanying appendix.)

B. Scope of Review

This Court reviews the Superior Court's decision on a motion for summary judgment *de novo*. *GMG Capital Invs., LLC v. Athenian Venture Partners I, L.P.*, 36 A.3d 776, 779 (Del. 2012); *Paul v. Deloitte & Touche, LLP*, 974 A.2d 140, 145 (Del. 2009). The Court "may affirm on the basis of a different rationale than that which was articulated by the trial court, if the issue was fairly presented to the trial court." *RBC Capital Markets, LLC v. Jervis*, 129 A.3d 816, 849 (Del. 2015) (citations omitted).

C. Merits of the Argument

SCD demonstrated below that (i) its fees for bilateral and multilevel procedures are comparable to those of its competitors; (ii) Delaware PIP carriers routinely pay the full amount charged by SCD for bilateral and multilevel procedures; (iii) State Farm itself has repeatedly done the same; (iv) SCD's per-

case revenues are reasonable, and close to the national average for ambulatory surgical centers; and (v) SCD has increased its fees just four times over the past 20 years, with each increase tracking the consumer price index. None of this is disputed, and taken together, it firmly establishes that State Farm's resort to Medicare reductions is unmoored from commercial reality: when a Delaware PIP carrier pays the full amount charged by SCD for bilateral and multilevel procedures, it is not "overpaying," but simply paying the going rate. And that rate has been overwhelmingly endorsed by the commercial conduct of Delaware PIP carriers and State Farm's own adjusters. This is not a "windfall" to SCD; it is simply the PIP statute's reasonableness requirement at work in the real world.

V. STATE FARM'S INVOCATION OF PRIVATE INSURERS AND MEDICARE IS CONFUSING AND CONFUSED, AND SHOULD BE REJECTED

A. Question Presented

Did the Superior Court err in its consideration of the rates paid by private health insurers pursuant to contract, and by Medicare pursuant to law? (Preserved at pages B241-43, B250, B254-57, B287-88, and B291-92 of the accompanying appendix.)

B. Scope of Review

This Court reviews the Superior Court's decision on a motion for summary judgment *de novo*. *GMG Capital Invs., LLC v. Athenian Venture Partners I, L.P.*, 36 A.3d 776, 779 (Del. 2012); *Paul v. Deloitte & Touche, LLP*, 974 A.2d 140, 145 (Del. 2009).

C. Merits of the Argument

SCD has shown, and the Superior Court confirmed, that comparisons to the fees approved by private health insurers under contract, or to fees dictated by Medicare, are irrelevant to the merits of this case. Superior Court Opinion at *4 ("The fact that State Farm, even with MPRs, is paying more than Medicare or a private health insurer is irrelevant when reduced payments from those payors are determined by federal law or private insurance contracts.") Confronted with this

result, State Farm has cast about for some form of coherent rebuttal on appeal. Its search has been in vain.

At page 2 of its opening brief on this appeal, State Farm argues that "other private insurance companies and Medicare routinely apply MPRs to Spine Care's bills," and that "Spine Care accepts these reductions without challenge." Yet at page 31 of the brief, State Farm insists that "MPRs have nothing to do with the negotiated contracts between providers and payors." Apparently, then, State Farm's position is that the argument presented at page 2 has nothing to do with this lawsuit — which is the same conclusion the Superior Court (correctly) reached.

Meanwhile, at page 28 of its opening brief, State Farm claims that the Superior Court refused to even consider the fact that State Farm ultimately pays more than "other types of payors" (though, as we have seen, State Farm pays far less than the ***exact same*** types of payors). Not so. Again, the Superior Court gave full consideration to this argument, and concluded that "[t]he fact that State Farm, even with MPRs, is paying more than Medicare or a private health insurer is irrelevant when reduced payments from those payors are determined by federal law or private insurance contracts." Superior Court Opinion at *4.

State Farm's arguments are confusing and confused. The Superior Court correctly rejected them.

VI. STATE FARM'S DISCUSSION OF WHETHER OTHER AMBULATORY SURGICAL CENTERS ACQUIESCE IN THE COMPANY'S USE OF MEDICARE REDUCTIONS IS REVEALING, THOUGH NOT IN THE WAY STATE FARM INTENDS

A. Question Presented

What inference, if any, should be drawn from the absence of evidence on whether other ambulatory surgical centers acquiesce in State Farm's application of Medicare reductions? (Preserved at page B305 of the accompanying appendix.)

B. Scope of Review

This Court reviews the Superior Court's decision on a motion for summary judgment *de novo*. *GMG Capital Invs., LLC v. Athenian Venture Partners I, L.P.*, 36 A.3d 776, 779 (Del. 2012); *Paul v. Deloitte & Touche, LLP*, 974 A.2d 140, 145 (Del. 2009).

C. Merits of the Argument

State Farm says that, "Importantly, Spine Care offered no evidence [below] that the other ambulatory surgical centers [in this locality] refuse to accept the application of MPRs."[39] The obvious answer is that SCD's competitors do not submit their PIP-related medical bills to SCD, so SCD has no access to those bills. It is a virtual certainty, however, that these competitors do submit such bills to State Farm — one of the most prolific, if not ***the*** most prolific, auto insurers in

[39] State Farm's opening brief on appeal, at 24.

Delaware. Yet State Farm offered no evidence below that SCD's competitors acquiesce in the company's use of Medicare reductions. Logically, if there is an adverse inference to be drawn here, it cannot be the one argued by State Farm.

VII. STATE FARM CANNOT PROPERLY ARGUE THE EXISTENCE OF ANY GENUINE ISSUE OF MATERIAL FACT

A. Question Presented

Can State Farm properly argue that this appeal involves genuine issues of material fact, when it agreed at oral argument below that no such issues exist? (Preserved at Superior Court Opinion at *3 ("At oral argument, both parties agreed there is no genuine issue of material fact and that this matter is ripe for decision on the merits based upon the record before this Court"); and at pages A349-52 of State Farm's appendix.)

B. Scope of Review

This Court reviews the Superior Court's decision on a motion for summary judgment *de novo*. *GMG Capital Invs., LLC v. Athenian Venture Partners I, L.P.*, 36 A.3d 776, 779 (Del. 2012); *Paul v. Deloitte & Touche, LLP*, 974 A.2d 140, 145 (Del. 2009).

C. Merits of the Argument

As the Superior Court correctly observed, "[a]t oral argument, both parties agreed there is no genuine issue of material fact and that this matter is ripe for decision on the merits based upon the record before this Court." Superior Court Opinion at *3. The transcript bears this out:

THE COURT: *** Do we have a 56(h) situation, Mr. Spadaro, where the parties are not contending that there is an issue of fact material [to] the disposition of either [cross-]motion and that the motions are being submitted for decision on the merits based on the record?

MR. SPADARO: For our part, [Y]our Honor, the answer is yes. ***

***

THE COURT: Well, can I just, then, ask you to pause briefly. Ask (*sic*) Mr. Wallace for your position on this limited issue.

***

Is it State Farm's position that this is a 56(h) situation?

MR. WALLACE: We do agree with that, [Y]our Honor. We think it's a 56(h). ***

So we think that you absolutely have in front of you all you need to rule, and that this is a 56(h) as a procedural matter because both parties are cross moving. And from State Farm's perspective, there aren't any fact disputes remaining that would necessitate a trial.

***

THE COURT: Okay. Well, what I'm going to hold you then to, Mr. Wallace, is in your portion of the argument, which we haven't gotten to yet, if State Farm feels that there is — and I'm reading from 56(h) — that there is an issue of fact material to the disposition of either motion, I want you to bring that to the Court's attention.

Otherwise, I believe what I'm hearing from the parties is that you believe that the record before the Court is sufficient to make a decision as to summary judgment, whether that goes in favor of SpineCare (*sic*) or in favor of State Farm. Have I stated that correctly?

> MR. WALLACE: You have correctly stated that, and we won't be arguing any fact disputes today.[40]

Despite State Farm's on-the-record representation to the Superior Court that no genuine issues of material fact exist, State Farm argues on appeal (at page 27 of its opening brief) that "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." This bait-and-switch should not be countenanced. State Farm should not be permitted to stipulate to the absence of genuine issues of fact, and then, unhappy with the result, argue precisely the opposite.

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[40] A350-53. The references to "56(h)" are to Superior Court Civil Rule 56(h), which provides:

> Where the parties have filed cross motions for summary judgment and have not presented argument to the Court that there is an issue of fact material to the disposition of either motion, the Court shall deem the motions to be the equivalent of a stipulation for decision on the merits based on the record submitted with the motions.

VIII. PIP LIMITS SHOULD NOT BE "CONSERVED" IN DEROGATION OF THE LAW, NOR IN DEROGATION OF THE INSURED'S INTERESTS

A. Question Presented

In paying admittedly covered PIP bills, can State Farm properly impose arbitrary reductions in the interest of "conserving" limits of liability? (Preserved at pages B299 and B312 of the accompanying appendix.)

B. Scope of Review

This Court reviews the Superior Court's decision on a motion for summary judgment *de novo*. *GMG Capital Invs., LLC v. Athenian Venture Partners I, L.P.*, 36 A.3d 776, 779 (Del. 2012); *Paul v. Deloitte & Touche, LLP*, 974 A.2d 140, 145 (Del. 2009).

C. Merits of the Argument

State Farm argues that, because PIP-related limits of liability are a finite resource, "conservation" of those limits advances the interests of its insureds and the purpose of the PIP statute. But when a PIP carrier arrogates to itself the right to impose arbitrary reductions on covered medical bills, the provider will naturally look to the patient — the carrier's insured — for payment of the balance. That result is manifestly contrary to the insured's interests; and it defeats the purpose of purchasing PIP coverage.

The PIP statute recognizes this. When the General Assembly speaks of "prevent[ing] the financial hardship and damage to personal credit ratings that can result from . . . unjustifiable delays" in the payment of PIP-related medical bills, *see* 21 *Del. C.* § 2118B(a), it is not contemplating the "conservation" of PIP limits. Rather, it is contemplating, as a matter of public policy, that covered medical bills in reasonable dollar amounts will be paid promptly and in full. Care providers, insureds, and the general public have a shared interest in that result.

CONCLUSION

For the reasons set forth above, plaintiff-below/appellee Spine Care Delaware, LLC respectfully requests that the Superior Court's well-reasoned decision be affirmed.

Respectfully submitted,

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February 17, 2020