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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
v.	)	C.A. No. K18C-07-008 NEP
SPINE CARE DELAWARE, LLC	)	
Plaintiff-Below, Appellee.	)	

APPELLANTS' REPLY BRIEF

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I. THE SUPERIOR COURT ERRED BY GRANTING SUMMARY JUDGMENT TO SPINE CARE BECAUSE SPINE CARE DID NOT ESTABLISH THAT STATE FARM'S APPLICATION OF MPRs IS INCONSISTENT WITH ITS OBLIGATION UNDER DELAWARE PIP LAW TO PAY "REASONABLE AND NECESSARY EXPENSES."

Spine Care's response brief makes clear from the outset that Spine Care misunderstands State Farm's position. Spine Care begins by arguing that "[t]he 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."[1] That is not State Farm's position. Spine Care is correct that the parties stipulated to a number of facts in this action and that one of those facts is that "'there is an ongoing controversy between SCD and State Farm with respect to whether State Farm is entitled to'" apply MPRs to multiple and bilateral procedures that are performed in a single operative session.[2] Spine Care also correctly recognizes that State Farm moved for summary judgment on the following issue:

> 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?[3]

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[1] Answering Br. at 15.
[2] *Id.* at 16 (quoting B2 ¶ 15).
[3] A110.

The Superior Court concluded 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.[4]

Contrary to Spine Care's argument, State Farm does not contend that the Superior Court asked the wrong question. Rather, State Farm argues that the Superior Court erred because, given the factual record that was before the Court, it ***reached the wrong answer*** as a matter of law. The Superior Court did this because it incorrectly placed the burden on State Farm to establish that its reductions were reasonable and held that Delaware's PIP statute prohibited State Farm from applying MPRs based on *nothing* from the PIP statute itself, but rather a misapplication of inapposite and non-binding caselaw.

Though Spine Care does not mention it once, the Superior Court expressly found that Spine Care had not established that its "fees for bilateral and multilevel procedures are reasonable as a matter of law."[5] Given that ruling, the Superior Court was required to grant summary judgment to State Farm. This is because the burden rests with the plaintiff to demonstrate that the expenses incurred under Delaware's

[4] Trial Court Order at 10.
[5] Trial Court Order at 5 n.15.

PIP statute were both reasonable and necessary, and if the plaintiff fails to carry this burden, the insurer has no obligation to pay.[6]

Spine Care does not dispute that the Superior Court placed the burden on State Farm to demonstrate the reasonableness of the MPRs. Spine Care seemingly attempts to argue that the stipulated facts that the parties made part of the record somehow changed the burden that would otherwise exist under Delaware law. That position is legally unsupported. Spine Care and State Farm agreed to stipulate to certain facts about the way Spine Care bills and the way State Farm pays to minimize discovery. The stipulated facts did not address, much less attempt to alter, well-settled Delaware law that makes clear that the burden of establishing entitlement to payment under Delaware's PIP statute rests with the provider, not with the insurer.[7]

Spine Care also argues that State Farm has the burden of demonstrating the reasonableness of its MPRs under this Court's decision in *Tackett v. State Farm Fire & Casualty Insurance Co.*[8] and Delaware's prompt payment statute, 21 *Del. C.* § 2118B(c). Spine Care did not present these arguments in the trial court, and

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[6] *Ramsey v. State Farm Mut. Ins. Co.*, 2005 Del. LEXIS 83, at *3 (Del. 2005); *see also Murphy v. United Servs. Auto Ass'n*, 2005 Del. Super. LEXIS 159, at *8 (Del. Super. Ct. May 10, 2006) ("As a matter of law, the burden lies on the Plaintiff, not on the insurer, to show the expenses were 'reasonable and necessary.'").

[7] *See Ramsey*, 2005 Del. LEXIS 83, at *3; *Murphy*, 2005 Del. Super. LEXIS 159, at *8.

[8] 653 A.2d 254, 264 (Del. 1995).

therefore has forfeited the right to assert them on appeal.[9] In any event, neither *Tackett* nor 21 *Del. C.* § 2118B(c) alter the fact that Spine Care bears the burden of establishing that the amounts that it bills State Farm are both reasonable and necessary. *Tackett* did not interpret Delaware's PIP statute at all. That case examined "the nature of a claim for bad faith arising out of an insurer's denial of policy benefits."[10] In examining that claim, this Court held that "[a] lack of good faith, or the presence of bad faith, is actionable where the insured can show that the insurer's denial of benefits was 'clearly without any reasonable justification.'"[11] Thus, *Tackett* confirms that, even in the bad faith context, ***the insured*** bears the burden of proof. To the extent that *Tackett* is applicable to Delaware's PIP statute at all, it supports State Farm's argument that the burden properly rests with Spine Care.

Spine Care's reliance on 21 *Del. C.* § 2118B(c) is also misplaced. That statute requires an insurer to "promptly process" PIP claims and, "if [the] claim is wholly or partly denied, provide the claimant with a written explanation of the reasons for

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[9] *See* Sup. Ct. R. 8 ("Only questions fairly presented to the trial court may be presented for review. . . ."); *Ghabayen v. State*, 93 A.3d 653 (Del. 2014) (Table) (recognizing that "arguments not fairly presented to the Superior Court" are "improper to present on appeal"). Spine Care does not even attempt to argue that the interests of justice require the Court to present these new arguments.

[10] *Tackett*, 653 A.2d at 264.

[11] *Id.* (quoting *Casson v. Nationwide Ins. Co.*, 455 A.2d 361, 369 (1982)).

such denial" within thirty days.[12] This case is not about prompt payment or prompt explanation of a denial of coverage.[13] It is about whether it is "reasonable and necessary" for Spine Care to insist on full payment for the second and successive injections performed in a single operative session. In that circumstance, the person or entity receiving payment bears the burden of demonstrating entitlement to the amount requested. So here, it is Spine Care's burden to show that State Farm's application of MPRs results in a payment that falls short of the PIP statute's command to pay "reasonable and necessary expenses."

This is confirmed by this Court's decision in *Ramsey v. State Farm Mutual Insurance Co.*[14] In *Ramsey*, the insured argued that State Farm improperly denied her PIP claim for lost wages for time she missed work to attend medical appointments.[15] State Farm denied the claim because the insured "presented no evidence that the appointments . . . had to be scheduled during work hours."[16] This Court affirmed the grant of summary judgment to State Farm, rejecting the argument that "State Farm had the burden to establish that she could have arranged her medical

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[12] 21 *Del. C.* § 2118B(c).
[13] Even if this case did involve an alleged violation of Delaware's prompt payment statute, Spine Care's argument overlooks 21 *Del. C.* § 2118B(d), which confirms that "[t]he burden of proving that the insurer acted in bad faith" by violating the prompt payment statute "shall be on the claimant," which in this case is Spine Care. 21 *Del. C.* § 2118B(d).
[14] 2005 Del. LEXIS 83 (Feb. 23, 2005).
[15] *Id.* at *1.
[16] *Id.* at *2.

treatment before or after work."[17] This Court emphasized that "[t]he PIP statute provides recovery only for 'reasonable and necessary expenses," and that in order to establish entitlement to any payment under the PIP statute, the insured "had to establish that her lost wages were unavoidable. Since she offered no evidence on that point, she failed to establish her entitlement to PIP benefits."[18] *Ramsey* therefore confirms that Spine Care, which is standing in the shoes of the insured, bears the burden of providing "evidentiary support" to establish that the amounts sought are both reasonable and necessary.[19]

In sum, Spine Care bears the burden of establishing that it is entitled to full payment for the second and successive injections performed in a single operative session. The Superior Court held that Spine Care had not carried that burden.[20] Given this holding, the Superior Court was required to deny Spine Care's motion for summary judgment. But, instead, the Superior Court placed the burden on State Farm to demonstrate that its use of MPRs is reasonable. For that reason alone, the Superior Court's decision must be reversed.

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[17] *Id.* at *2-3.
[18] *Id.* at *3.
[19] *See id.*
[20] Trial Court Order at 5 n.15.

II. EVEN IF STATE FARM HAD THE BURDEN OF DEMONSTRATING THAT THE USE OF MPRs WAS REASONABLE, STATE FARM SATISFIED THAT BURDEN AND IS ENTITLED TO SUMMARY JUDGMENT.

A. State Farm Was Not Required to Correlate the MPRs to Specific Duplicative Services and the Superior Court Erred in Holding Otherwise.

Spine Care also contends that it is entitled to summary judgment because, according to Spine Care, in order to be entitled to apply the MPRs, State Farm is required to "correlate its reductions to particular, duplicative services."[21] But Spine Care's position – and the Superior Court's Order – ignore basic principles of medical billing, and are inconsistent with the manner in which Spine Care itself calculates the amount that it bills. Spine Care charges a fixed rate for each procedure that does not "correlate" to its costs or the efforts that Spine Care is required to expend when patients receive spinal injections at its facility. Spine Care offers no explanation for why it is reasonable for Spine Care to charge a fixed rate regardless of the unique circumstances presented by a given patient, but at the same time, it is purportedly unreasonable for State Farm to apply a fixed percentage reduction without correlating it to a particular patient.

Accepting Spine Care's argument would improperly force State Farm to pay whatever amount that Spine Care chooses to bill, regardless of whether that amount

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[21] Answering Br. at 23.

is reasonable or not. In order to apply any kind of reduction to the amount that Spine Care bills, State Farm would be required to "correlate" the amount of its reductions, on a patient-by-patient basis, to each specific procedure that Spine Care performs. This would be impossible in practice for many reasons, including because Spine Care does not provide State Farm with information about its costs for each procedure that it performs, which vary because "every single patient and every single procedure is different."[22] Moreover, as Spine Care recognizes in its Answering Brief, insurers have a statutory obligation to promptly pay PIP claims. Requiring insurers to establish a direct correlation between MPRs and each specific procedure in this limited timeframe would be extremely burdensome and would risk slowing down the processing of PIP claims.

In any event, State Farm ***did*** offer evidence to substantiate the reasonableness of the amount of the MPRs that State Farm applies. This evidence was substantial. It was focused on the well-accepted standard practices for addressing multiple procedures in the same operative session that are utilized by all types of providers and payors in the medical billing and coding industry. And it was largely undisputed.

In fact, the parties stipulated at the outset of this dispute that "State Farm applies the Medicare Claim Processing Guidelines in its reimbursements to [Spine Care] for bilateral spinal procedures and spinal procedures performed at multiple

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[22] A94.

vertebral levels in in the same operative session."[23] Under those Guidelines, when physicians at an ambulatory surgery center (ASC) perform 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."[24] Similarly, when physicians at an ASC perform bilateral injections in a single operative session, "[t]he ASC is paid 100% for the first side and 50% for the second side."[25]

Nicole Bonaparte, State Farm's expert witness who Spine Care did not depose or otherwise challenge, submitted a report in which she opined that "[i]t is reasonable and customary in the industry for payers to follow the Medicare Claim Processing Guidelines when reimbursing providers for bilateral spinal injections" and when reimbursing providers for spinal injections performed at multiple vertebral levels as part of a single operative session. Spine Care's own expert witness also confirmed that the Medicare Claim Processing Guidelines are widely used as a leading manual for how to bill and how to pay.[26]

In short, contrary to Spine Care's argument, State Farm did not come up with the percentage by which it reduces the amount it pays Spine Care for the second and

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[23] A141 ¶ 9.
[24] A141 ¶ 7.
[25] A141 ¶ 7.
[26] Deposition of Toni M. Elhoms at 116:2-117:4.

successive injections out of thin air. State Farm applies reductions that are widely recognized in the industry and that the undisputed expert testimony confirms are reasonable. That is all that Delaware law requires.[27] The Superior Court erred by rejecting all of this evidence supporting State Farm's application of MPRs. This Court should reverse.

B. English, *Anticaglia*, and *Watson* Do Not Support Spine Care's Position.

Spine Care discusses three Superior Court decisions at length to support its position 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."[28] These cases do not support Spine Care's position. *General Motors Corp. v. English*, which Spine Care discusses at length, does not interpret Delaware's PIP statute at all.[29] *English* involved General Motors' attempt to pay a medical provider, for workers' compensation claims, the same rates the provider negotiated with private insurers.[30] The Superior Court concluded that it was not unreasonable for the medical provider to charge General Motors more than the amount that it charged private insurers with which the medical provider had a contractual

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[27] *See Murphy v. United Servs. Auto Ass'n*, 2005 Del. Super. LEXIS 159, at *10 (Del. Super. Ct. May 10, 2005) ("The words 'reasonable and necessary qualify the scope of the delineated benefits that an insurance company must pay.").
[28] Answering Br. at 24.
[29] 1991 Del. Super. LEXIS 180 (Del. Super. Ct. May 10, 1991).
[30] *Id.* at *2.

relationship, reasoning that "GM 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."[31]

That case is wholly inapposite. Unlike the defendant in *English*, State Farm ***is not*** seeking to pay discounted rates that Spine Care has agreed to accept from insurance providers with which it contracts. It is undisputed that State Farm pays Spine Care's standard rates and is merely seeking to apply MPRs to multiple injections in the same operative session. Thus, unlike in *English*, State Farm is not attempting to take advantage of Spine Care's contract with any private health insurer. Even factoring in the MPRs, State Farm consistently pays Spine Care substantially more than any other private insurer for comparable procedures.[32]

English is also distinguishable for at least two other reasons. As Spine Care recognizes, *English* relied upon a presumption that the provider's charges were reasonable that is applicable in the workers' compensation context, but does not apply in the PIP context. As discussed above, Delaware courts have held that "[a]s a matter of law, the burden lies on the Plaintiff, not the insurer, to show the expenses were 'reasonable and necessary.'"[33] Second, *English* involved the review of an

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[31] *Id.* at *5-6.
[32] Opening Br. at 30; A148-58. As discussed in State Farm's Opening Brief, the Superior Court conflated discounted rates and MPRs in its analysis and that confusion seems to be part of what led to its error. *See* Opening Br. at 30-31.
[33] *Murphy*, 2005 Del. Super. LEXIS 159, at *8.

administrative determination with the Superior Court sitting in review and applying a deferential substantial evidence standard.

Spine Care's (and the Superior Court's) reliance on *Anticaglia v. Lynch* is similarly misplaced.[34] That case also did not interpret Delaware's PIP statute. It involved a provider's attempt to recover unpaid fees for medical services rendered under a *quantum meruit* theory.[35] The Superior Court set forth a number of factors that are relevant to determining "a reasonable and customary fee" that a physician is entitled to recover based on a *quantum meruit* claim. Those factors are:

> 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.[36]

Contrary to Spine Care's assertion, *Anticaglia* does not suggest that the most important factor is "the dollar amount charged by other medical professionals in the locality for the same services."[37] As the Superior Court recognized in its summary judgment order, that is only one of many factors that indicate whether a provider's fees are reasonable, and Spine Care has not offered ***any*** evidence about the other

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[34] 1992 Del. Super. LEXIS 1222 (Del. Super. Ct. Feb. 6, 1992).
[35] *See id.* at *12.
[36] *Id.* at *18-19.
[37] *See* Answering Br. at 24.

factors.[38] Furthermore, unlike the question before the court in *Anticaglia*, this case does not involve the reasonableness of a specific bill to a specific provider for services previously rendered. It involves State Farm's ability to apply an industry-standard MPRs when multiple spinal injections are performed in a single session.

Watson v. Metropolitan Property & Casualty Insurance Co.,[39] is distinguishable for the same reason. By relying on cases that analyze the reasonableness of a specific bill for a procedure performed on a specific patient, the Superior Court has jammed a square peg into a round hole. It is inherently reasonable for State Farm to apply a widely-accepted industry standard MPR to Spine Care's billing for multiple spinal injections performed in a single operative session. State Farm's expert and other evidence in the record discussed above amply establishes the rationale and reasonableness of MPRs. The Superior Court erred by ignoring all of this evidence and instead applying out-of-context unpublished trial court decisions to implicitly require a patient-by-patient correlation that is incompatible with the issues in this case.

Beyond that, *Watson* recognizes that "a claimant to medical expense benefits under a relevant no-fault statute bears the burden of proof to establish by a preponderance of the evidence that the medical services received were necessary and

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

[39] 2003 Del. Super. LEXIS 344 (Del. Super. Ct. Oct. 2, 2003).

that the bills or the charges for such services were reasonable."[40] Because the Superior Court found that Spine Care had not carried its burden in this regard, Spine Care was not entitled to summary judgment.[41]

Moreover, while Spine Care is incorrect in claiming that the "chief indicium of the reasonableness of medical fees"[42] is the amount that other medical professionals charge, even if that were true it would not support Spine Care's position that State Farm's application of MPRs is unreasonable. The only evidence that Spine Care has offered to support the reasonableness of its rates is evidence that the standard rates that it charges are similar to the standard rates charged by two other ambulatory surgery centers in New Castle County. This evidence is irrelevant to whether State Farm is permitted to apply MPRs because Spine Care offers

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[40] *Id.* at *20 (alterations and internal quotation marks omitted).

[41] Spine Care spends an entire subsection of its argument discussing *Casson v. Nationwide Ins. Co.*, 455 A.2d 361 (Del. Super. Ct. 1982). Spine Care argues that State Farm takes *Casson* out of context. But State Farm's only reference to *Casson* in its opening brief is a parenthetical noting that the Superior Court quoted *Casson* in its *Murphy* decision. State Farm relies on *Murphy* to support its argument that Delaware's PIP statute is satisfied so long as the insurer pays a reasonable amount. *See Murphy*, 2005 Del. Super. LEXIS 159, at *10. Spine Care does not mention *Murphy* at all. *Murphy's* holding is consistent with persuasive authority in other jurisdictions with PIP statutes similar to Delaware's. *See Nhem v. Metropolitan Prop. & Cas. Ins. Co.*, 1997 Mass. App. Div. 84, 87 (Mass. App. Ct. 1997) ("[A]n insurer is not statutorily obligated to make automatic payment of the full amount of all PIP claims irrespective of the reasonableness of the amounts charged for medical services.").

[42] Answering Br. at 24.

absolutely no evidence about whether those other providers insist on full payment for the second and successive injections performed in a single operative session.[43]

Spine Care's only response to its failure to offer this evidence is to argue that an adverse inference about the billing practices of other providers should be drawn against State Farm because Spine Care's "competitors do not submit their PIP-related medical bills to [Spine Care], so [Spine Care] has no access to those bills."[44] This argument is meritless. Spine Care was able to determine its competitors' standard rates. There is no logical reason why Spine Care also could not have subpoenaed its competitors to determine whether they accept MPRs from PIP insurers. Because Spine Care failed to develop any evidence on this point, Spine Care did not satisfy ***its*** burden.[45]

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[43] In fact, Spine Care's irrelevant competitor rate evidence actually indicates otherwise. The rates of one of Spine Care's competitor providers show a self-imposed reduction for second and successive injections. *See* Aff't of Toni Elhoms, Ex. D to Spine Care's Opening Brief in Support of its Motion for Summary Judgment ¶¶ 3-4; *see also* A341 (conceding that Christiana Spine Center applies MPRs); A415-16, A429-32 (discussing same at MSJ hearing with Spine Care conceding competitor self-imposes MPRs).

[44] Answering Br. at 39.

[45] *See South v. State Farm Mut. Auto. Ins. Co.*, 2012 Del. Super. LEXIS 494, at *5 (Del. Super. Ct. Sept. 28, 2012) ("Plaintiff has not proffered expert testimony substantiating either the reasonableness of his expenses, or their causal nexus to the accident in question. Because Plaintiff failed to present sufficient evidence to support essential elements of his claim, the Court cannot conclude, as a matter of law, that he is entitled to recover PIP benefits from Defendant.").

C. Spine Care Misconstrues the Relevance of the Evidence State Farm Offered Regarding the Payment Practices of Medicare and Private Insurers.

Spine Care also contends that its fees are reasonable because "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."[46] But Spine Care cites no authority to support its bald assertion that "the amount generally paid by the same class of payors for the same or similar service" is a relevant factor for assessing whether a provider's fees are reasonable, and that is not one of the factors set forth in any of the cases that Spine Care relies upon to support its reasonableness argument.[47]

Spine Care's suggestion that a determination of reasonableness should be limited to a single "class of payors" is illogical, as the costs to Spine Care in hosting the procedure at its facility do not vary based on the identity of the payor. In other words, a bilateral spinal injection performed on a particular patient takes the same amount of time, requires the same amount of difficulty, and costs Spine Care the same amount regardless of whether that patient is a PIP claimant or covered by Medicare or another private insurance company. Indeed, Spine Care's own expert testified that the amount that Spine Care receives from other types of payors is an

[46] Answering Br. at 29.
[47] *See id.* (emphasis omitted).

"important" factor in assessing whether the amount that State Farm pays is reasonable,[48] and Spine Care's expert disclosure concedes that "[t]he reasonableness of SCD's PIP-related fees should . . . be evaluated by reference to fees charged for the same services in the private healthcare marketplace."[49]

Spine Care's argument that it is inappropriate to look at the amount that Spine Care receives from payors other than PIP insurers is based on the conflation of two very different concepts – the fee schedules that federal law obligates Spine Care to accept when it sees patients by Medicare and that Spine Care contractually agrees to with in-network insurance companies and the MPRs that exist to avoid giving the provider a windfall when multiple procedures are performed as part of a single operative session. MPRs have nothing to do with negotiated contracts between providers and payors. The undisputed evidence before the Superior Court demonstrates that MPRs exist because "[w]hen multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work."[50]

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[48] A46.

[49] Ex. 12 to Transmittal Aff't of Colin Shalk in Support of Defendants' Motion for Summary Judgment ¶ 2.

[50] A215; *see also* 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

Unlike Medicare and private insurance companies, State Farm pays Spine Care according to Spine Care's standard billing rate. In other words, State Farm pays 100% of Spine Care's billed amount for the first injection and then applies MPRs for to Spine Care's full billed amount for the second and successive injections.[51] By contrast, other types of payors pay Spine Care substantially reduced amounts for the first injection and then apply MPRs to those reduced amounts, further reducing the amount that Spine Care receives.[52] The end result is that State Farm pays Spine Care as much as several multiples more than virtually all other types of payors for the same times of claims.

In the example set forth in State Farm's opening brief, State Farm paid Spine Care nearly three times as much as the next closest payor for certain kinds of bilateral spinal injections performed in a single operative session.[53] Thus, when looking at the "private healthcare marketplace" as a whole, as Spine Care's own expert disclosure admits is appropriate, it is clear that the amount State Farm pays Spine Care is not only "reasonable," it is far more than Spine Care receives from other types of payors.

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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.").

[51] *See, e.g.*, A147-58.

[52] *See, e.g.*, *id.*

[53] *See* Opening Br. at 29-30.

Moreover, that some other PIP insurers in Delaware have decided to not challenge Spine Care's attempt to treat PIP insurers differently than other payors by demanding overpayment for bilateral and multiple level injections in no way suggests that State Farm is somehow unreasonable in insisting on not overpaying for such injections. It simply cannot be the said that State Farm is failing to meet its obligation to pay "reasonable and necessary expenses" when it is paying Spine Care in a manner that is consistent with well-accepted industry standards, especially when doing so avoids overpayment and preserves the insured's limited PIP coverage. The Superior Court respectfully erred in concluding otherwise.[54]

D. Spine Care's Argument that the Superior Court's Decision Is Supported by Independent and Alternative Bases Fails.

Spine Care also argues that it was entitled to summary judgment because the Superior Court's decision is purportedly "supported by independent and alternative bases that were fully presented below."[55] But Spine Care fails to identify any

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[54] Furthermore, Spine Care's attempts to point out that State Farm has mistakenly paid some Spine Care's bills without applying MPRs should be squarely rejected. It is undisputed that Spine Care bills bilateral and multiple level injections without including the MPR even though they are aware that State Farm applies MPRs. That there have been some occasions where State Farm has mistakenly overlooked the procedure code and not applied the MPR is unsurprising and probative of nothing. More importantly, while Spine Care touts the importance of the agreed upon stipulated facts, one such key fact was that State Farm applies MPRs to Spine Care's bills for bilateral and multiple level injections. A141 ¶ 9. Spine Care's attempt to seize upon occasions where State Farm has inadvertently failed to apply an MPRs is directly contrary to that stipulated fact.

[55] Answering Br. at 35.

independent or alternative grounds for the Superior Court's holding at all, merely recycling its same argument that Spine Care's insistence on the full amount of its standard rates for the second and successive injections performed in a single operative session is reasonable. That argument fails for all of the reasons discussed in State Farm's opening brief and above.

Spine Care's assertion that "when a Delaware PIP carrier pays the full amount charged by [Spine Care] for bilateral and multilevel procedures, it is not 'overpaying,' but simply paying the going rate," is particularly absurd.[56] As discussed in State Farm's opening brief and above, even when State Farm applies MPRs, it pays vastly more – often ***several times more*** – than the "going rate" Spine Care accepts from other payors.

[56] *See id.* at 36.

III. AT A MINIMUM, STATE FARM ESTABLISHED THAT THERE IS A DISPUTED ISSUE OF MATERIAL FACT THAT REQURIED THE DENIAL OF SUMMARY JUDGMENT.

Spine Care also takes issue with State Farm's argument that, at a minimum, there is a disputed issue of material fact that precluded the entry of summary judgment. According to Spine Care, State Farm "stipulate[d] to the absence of genuine issues of fact" in the Superior Court and is therefore precluded from taking a different position before this Court. But Spine Care takes isolated portions of the transcript of the summary judgment hearing out of context. State Farm expressly recognized the possibility that "there could be a fact question" if "the real issue was the reasonableness of Spine Care's fees" and stated that there was daylight "between summary judgment for State Farm and summary judgment for Spine Care" because the court "could potentially find a fact question and want to hear from the witnesses that have been deposed in this case." [57]

Moreover, regardless of whether it is characterized as a fact dispute or not, Delaware law is clear that "[s]ummary judgment is not appropriate when the Court determines that it does not have sufficient facts in the record to enable it to apply the law to the facts before it."[58] Here, the Superior Court concluded that it did not have enough evidence to determine that Spine Care's insistence on full payment for the

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[57] A351-53.

[58] *South*, 2012 Del. Super. LEXIS 494, at *5.

second and successive injections performed in a single operative session was reasonable.[59] Upon reaching that conclusion, the only legally permissible result was to deny Spine Care summary judgment.

[59] Trial Court Order at 5 n.15.

IV. ACCEPTING SPINE CARE'S POSITION WOULD UNDERMINE THE PURPOSE OF DELAWARE'S PIP STATUTE TO THE DETRIMENT OF DELAWARE INSUREDS.

Spine Care does not directly address State Farm's argument that Spine Care's refusal to accept MPRs would harm Delaware insureds by exhausting their PIP coverage more quickly solely to ensure that Spine Care maximizes its profits. Spine Care's only response is to halfheartedly argue that ***State Farm's*** position would harm Delaware insureds because, according to Spine Care, "the provider will naturally look to the patient – the carrier's insured – for payment of the balance" of the difference between the insurer's payment and the full standard rack rate. But Spine Care's hypothetical argument is inconsistent with the record evidence and should be rejected on that basis alone. Spine Care's corporate designee testified that it is ***not*** Spine Care's practice to "balance bill" the insureds and that, even though it does not do so, Spine Care profits from the services it renders to State Farm's insureds.[60]

[60] B161.

CONCLUSION

For all of these reasons, and those in State Farm's opening brief, the Superior Court erred by granting summary judgment to Spine Care. State Farm respectfully requests that the Superior Court's decision be reversed.

Dated: March 3, 2020

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