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Commonwealth of Kentucky

Court of Appeals

NO. 2014-CA-002017-MR

ANITA HOUCHENS AND JORDAN SANDERS, INDIVIDUALLY AND AS CLASS REPRESENTATIVES — APPELLANTS

v.

APPEAL FROM JEFFERSON CIRCUIT COURT
HONORABLE MARY M. SHAW, JUDGE
ACTION NO. 13-CA-000176

GOVERNMENT EMPLOYEES INSURANCE COMPANY — APPELLEE

OPINION
REVERSING AND REMANDING

** ** ** ** **

BEFORE: COMBS, DIXON, AND STUMBO, JUDGES.

DIXON, JUDGE: Appellants, Anita Houchens and Jordan Sanders, appeal from an opinion and order of the Jefferson Circuit Court granting Appellee's, Government Employees Insurance Company (GEICO), motion for summary

judgment. For the reasons set forth herein, we reverse and remand the matter for further proceedings.

On July 28, 2011, Appellants were injured in an automobile accident in Louisville, Kentucky. Shortly thereafter, both sought treatment from a chiropractor for injuries they allegedly sustained in the accident, submitting their bills to GEICO, their automobile insurer, for payment under their basic reparations benefits ("BRB") policy. Upon receiving Appellants' BRB applications, GEICO requested their medical records.

In mid-October, GEICO retained Integrity, a third-party medical consulting company located in Minnesota, to conduct independent medical reviews of Houchens' and Sanders' records. On October 21, 2011, Dr. Julie Samson, an orthopedic surgeon in Minneapolis, Minnesota, submitted a report stating that based upon her review of some of Houchens' medical records, she concluded that treatment was not reasonable or necessary after August 17, 2011. As a result, GEICO notified Houchens on November 15, 2011, that her no-fault benefits were terminated, retroactively effective October 14, 2011. At the time benefits were terminated, GEICO had paid $4,442 and Houchens had a remaining $4,710 in outstanding charges.

Similarly, on October 19, 2011, Dr. Harvey Bishow, also an orthopedic surgeon in Minneapolis, Minnesota, submitted a report stating that based upon his review of some of Sanders' medical records, he concluded that treatment was not reasonable or necessary after September 28, 2011. GEICO

thereafter notified Sanders on November 15, 2011, that his no-fault benefits were terminated, retroactively effective September 28, 2011. At the time his benefits were terminated, GEICO had paid $3,680 and Sanders had another $3,680 in outstanding charges.

In January 2013, Appellants filed an action in the Jefferson Circuit Court against GEICO, individually and as class representatives, to recover outstanding no-fault benefits, 18% interest on the overdue benefits, and attorney fees as a result of GEICO unilaterally terminating payment via its self-generated "paper review." The case was then removed to federal court and, following GEICO's appeal to the Sixth Circuit Court of Appeals, was returned to the Jefferson Circuit Court. The trial court thereafter granted class certification and simultaneously entered summary judgment in favor of GEICO, finding that nothing in Kentucky's Motor Vehicle Reparations Act ("MVRA"), Kentucky Revised Statutes (KRS) 304.39-010 et seq., prohibits a reparations obligor from denying or terminating benefits based solely upon a review of an insured's medical records. This appeal ensued.

Our standard of review on appeal of a summary judgment is "whether the trial court correctly found that there were no genuine issues as to any material fact and that the moving party was entitled to judgment as a matter of law." *Scifres v. Kraft*, 916 S.W.2d 779, 781 (Ky. App. 1996). Summary judgment shall be granted "if the pleadings, depositions, answers to interrogatories, stipulations, and admissions on file, together with the affidavits, if any, show that there is no

genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Kentucky Rules of Civil Procedure (CR) 56.03. The trial court must view the record "in a light most favorable to the party opposing the motion for summary judgment and all doubts are to be resolved in his favor." *Steelvest v. Scansteel Service Center, Inc.*, 807 S.W.2d 476, 480 (Ky. 1991). Summary judgment is proper only "where the movant shows that the adverse party could not prevail under any circumstances." *Id.*

The sole issue on appeal is whether a reparations obligor in Kentucky is entitled to utilize "paper reviews," which are not tendered to nor reviewed by a court, as the sole basis for terminating or denying an insured's no-fault benefits. Appellants contend that the only medical review expressly sanctioned by Kentucky's MVRA is contained in KRS 304.39-270 and requires court oversight. GEICO, on the other hand, argues that the statutory language is purely permissive in nature, and that it has the discretion whether to utilize the statutory procedure or to seek its own paper review of an insured's medical records.

Kentucky's MVRA, KRS 304.39-010 et seq., which became effective on July 1, 1975, requires automobile insurers in Kentucky to provide coverage for reasonable and necessary medical expenses arising from a covered automobile accident without regard to fault. These insurance benefits are referred to as basic reparations benefits ("BRB"), but are also commonly referred to as personal injury protection ("PIP") benefits or "no-fault" benefits. The purpose of the Act, as set forth in KRS 304.39-010, is as follows:

(1) To require owners, registrants and operators of motor vehicles in the Commonwealth to procure insurance covering basic reparation benefits and legal liability arising out of ownership, operation or use of such motor vehicles;

(2) To provide prompt payment to victims of motor vehicle accidents without regard to whose negligence caused the accident in order to eliminate the inequities which fault-determination has created;

(3) To encourage prompt medical treatment and rehabilitation of the motor vehicle accident victim by providing for prompt payment of needed medical care and rehabilitation;

(4) To permit more liberal wage loss and medical benefits by allowing claims for intangible loss only when their determination is reasonable and appropriate;

(5) To reduce the need to resort to bargaining and litigation through a system which can pay victims of motor vehicle accidents without the delay, expense, aggravation, inconvenience, inequities and uncertainties of the liability system;

(6) To help guarantee the continued availability of motor vehicle insurance at reasonable prices by a more efficient, economical and equitable system of motor vehicle accident reparations;

(7) To create an insurance system which can more adequately be regulated; and

(8) To correct the inadequacies of the present reparation system, recognizing that it was devised and our present Constitution adopted prior to the development of the internal combustion motor vehicle.

Kentucky's "MVRA is to be liberally interpreted in favor of the accident victim."

See Fields v. Bellsouth Telecommunications, 91 S.W.3d 571, 572 (Ky. 2002).

Blue Cross and Blue Shield Inc. v. Baxter, 713 S.W.2d 478, 480 (Ky. App. 1986), *overruled on other grounds in Steelevest*, 807 S.W.2d 476, 480 (Ky. 1991).

> [I]n enacting no-fault legislation, the intent was to provide a remedy to automobile accident victims that could not be impinged upon by any means whatsoever. This was the victim's reward for sacrificing traditional tort rights. . . . It is remedial in nature and thus will be broadly construed to carry out its beneficial purpose of providing compensation for persons injured by automobiles. 7 Am.Jur.2d *Automobile Insurance* § 28 (1980).

Accordingly, Kentucky's MVRA requires an insurer to pay a medical expense within thirty days of receiving "reasonable proof of the fact and amount of loss realized[.]" KRS 304.39-210(1). Significantly, "[t]here shall be a presumption that any medical bill submitted is reasonable." KRS 304.39-020(5)(a). Further, if an insurer wrongfully delays or denies payment, Kentucky's MVRA affords the insured a remedy by providing for recovery of 18% per annum interest an all overdue payments. In addition, "a reasonable attorney's fee for advising and representing a claimant on a claim or in an action for basic or added reparation benefits may be awarded by the court if the denial or delay was without reasonable foundation." KRS 304.39-220(1).

KRS 304.39-270(1), the statutory provision at issue herein, states as follows:

> If the mental or physical condition is material to a claim for past or future basic added reparations benefits, the reparation obligor may petition the circuit court for an order directing the person to submit to a mental or physical examination by a physician. Upon notice to the

> person to be examined and all persons having an interest, the court may make the order for good cause shown. The order shall specify the time place, manner, conditions, scope of the examinations, and the physician by whom it is to be made.

The trial court below agreed with GEICO that the phrase "may petition the court" means that a reparations obligor may, but is not required, to seek a court order for an independent medical exam ("IME") prior to terminating or denying benefits. We disagree and conclude that such interpretation violates both the intent and spirit of Kentucky's MVRA.

Whether KRS 304.39-270(1) provides the sole statutory mechanism for a reparations obligor to challenge an insured's medical bills has yet to be addressed by a Kentucky court. Rather, the decisions examining the statutory provision have focused on the standard for obtaining a court-ordered IME. In *Grant v. State Farm Mutual Automobile Insurance Co.*, 896 S.W.2d 24 (Ky. App. 1995), a panel of this Court reversed and remanded the circuit court's order requiring the insured to submit to an IME. The panel criticized the petition of the reparations obligor as failing to adequately explain why an IME was necessary. The panel concluded that "the statute is explicit in its requirement of 'good cause shown'" and that a "circuit court may not enter an order for an examination without rhyme or reason, thereby entitling a reparation obligor to an examination simply upon demand." *Id.* at 26.

In *Miller v. United States Fidelity & Guaranty Co.*, 909 S.W.2d 339 (Ky. App. 1995), the insured sought medical treatment following a car accident. The

insurer, U S F & G, subsequently contested the necessity of the treatments and refused to pay the insured's bills. Instead, it scheduled the insured for an IME. However, the insured refused to attend, arguing that pursuant to Kentucky's MVRA, the insurer was required to first obtain a court order for the IME. U S F & G subsequently petitioned for and obtained an order requiring the insured to submit to an IME, the trial court having concluded that U S F & G demonstrated good cause as required by KRS 304.39-270.

On appeal to this Court, the insured argued, in part, that the lower court had erred in finding that U S F & G had shown good cause for an IME, because such finding was based solely upon an affidavit submitted by a U S F & G claims adjuster stating that the extent of the insured's claimed injuries was disproportionate to the extent of the car accident. Noting that Kentucky had little case law interpreting and applying the "good cause" standard of the independent examination provision other than the *Grant* decision, this Court looked to Pennsylvania, which had enacted a similar provision as a part of its no-fault act.

> [I]n *State Farm Ins. Co. v. Swantner*, 406 Pa.Super. 235, 594 A.2d 316 (1991), the Pennsylvania court provided an extensive analysis of case law that had interpreted the "good cause" standard of its independent examination provision.
>
> In that case, the obligor also questioned the necessity of the treatment rendered to its insured, who claimed that she had sustained a cervical strain in a car accident. As in the instant case, the company requested that its insured submit to an independent medical examination. The court determined that indeed the insurer had met its burden of showing "good cause" for the independent

> examination by documenting and demonstrating *more than a mere suspicion* that its insured's treatments were unnecessary or unreasonable. First, State Farm had submitted the insured's medical reports to peer review evaluation, which had indicated that the treatments were excessive—if not unnecessary. The company then informed the insured of the results of the peer review's evaluation and requested in writing that the insured's treating physician supplement his medical reports in an effort to address some of the company's specific concerns. The court concluded that entry of the order requiring the independent evaluation was not an abuse of discretion because the company's prior contacts and inquiries made it "evident that all reasonable non-intrusive means had been pursued to establish the justification or lack of it for continued payment." *Id.* at 246.
>
> The Pennsylvania court declined to enumerate specific factors to be considered when determining whether "good cause" has been shown by an insurer. Instead, it opted for a case-by-case analysis, with emphasis on the ability of an insurer to demonstrate affirmative proof that "good cause" exists for an independent evaluation to be conducted. We believe that this is a reasonable approach and hereby adopt it as our own.

Miller, 909 S.W.2d at 342. Applying the above analysis to the facts presented, the *Miller* Court concluded that the U S F & G claims representative's affidavit was insufficient to demonstrate good cause:

> We are unpersuaded that these general averments alone by an employee of the insurer rather than an independent medical professional are sufficient to constitute "good cause." In fact, these remarks amount to little more than boilerplate. The medical reports submitted by Miller were apparently never reviewed by an independent health care provider; the credentials of Miller's treating physician were not questioned; the treating physician was never requested to provide further documentation or to

> answer any specific concerns; no explanation regarding how another examination could be expected to satisfy the company's misgivings was provided; and finally, no specific reasons supporting the company's doubts about the necessity for treatment were provided. . . . As we have noted, the insurer is not entitled to an independent medical examination upon demand. *Grant, supra*.

Id., 342-43. Finally, the *Miller* Court rejected U S F & G's argument that notwithstanding KRS 304.39-270(1)'s "good cause" requirement, the insured was obligated to submit to an IME pursuant to the provisions of the insurance policy:

> As the Kentucky Supreme Court has noted, "[t]he primary purpose of the MVRA is to benefit motor vehicle accident victims by reforming, and in some areas broadening, their ability to make and collect claims." *Crenshaw v. Weinberg*, Ky., 805 S.W.2d 129 (1991). The statute clearly sets forth the standard by which an insured can be forced to undergo independent medical examination and creates a statutory presumption of reasonableness of medical bills as submitted. Public policy underlying that statute dictates that U S F & G may not enforce an overreaching policy provision requiring an independent medical examination "when and as often as the company may reasonably require" in clear derogation of the statutory language."

Id. at 343.

Although acknowledging there is limited case law on the issue presented, the trial court herein noted in its opinion and order that it found the decision in *White v. Allstate Insurance Company*, 265 S.W.3d 254 (Ky. App. 2007), to be instructive. Therein, Appellants began treatment at Knopp Chiropractic in April 2005 for injuries they sustained in an automobile accident. Appellants' bills were submitted to Allstate for payment of basic reparation benefits. In September 2005, after

becoming concerned that Appellants' treatment had been unusually prolonged, Allstate sent several requests to Knopp for an explanation as to the necessity of the continuing treatment. When Knopp failed to respond, Allstate requested that Appellants each undergo an IME. Both refused. Allstate then retained a chiropractor, Michael R. Hillyer, to perform a peer review of Appellants' medical records. Dr. Hillyer concluded that the medical records failed to indicate a nexus between the treatments and the motor vehicle accident, failed to document the medical necessity of the treatments, and failed to provide a treatment plan. He further opined that some of the fees were excessive. Based upon Dr. Hillyer's report, Allstate filed a petition in the circuit court pursuant to KRS 304.39-270(1) to compel Appellants to undergo IME's. Following a hearing, the trial court granted Allstate's petition.

On appeal, a panel of this Court noted that KRS 304.39-270(1) expressly permits an independent medical examiner to evaluate basic reparation benefit claims. "However, equally clear is that the insurer cannot compel its insured to submit to an independent medical examination simply upon demand without 'good cause.'" *Id.* at 256. After discussing what constitutes "good cause," this Court concluded that the peer record review by Dr. Hillyer did, in fact, demonstrate good cause for the court-ordered independent medical examinations. *Id.*

We are of the opinion that the trial court misconstrued the *White* decision as supporting GEICO's position. We discern a distinct difference between the use of a medical records review by a reparations obligor for the purpose of establishing

good cause for a court-ordered IME and the use of a medical records review by that obligor for the purpose of unilaterally denying or terminating an insured's benefits. Clearly, as is evidenced by the case law discussed herein, our legislature enacted KRS 304.29-270(1) as a safeguard against the misuse of IME's. Not only must the obligor demonstrate good cause for the IME, but the court is then required to set the time, place, manner, conditions, scope of the examination, and the physician by whom it is to be made. It is beyond reason that the legislature would require court oversight of an IME of an insured yet would condone that insured's benefits being terminated or denied solely based upon a unilateral paper review of his or her medical records. We must agree with Appellants that the position asserted by GEICO would essentially make it the judge, jury and executioner. We are of the opinion that such violates the intent and purpose of Kentucky's MVRA.

GEICO argues in this Court that in the unpublished decision in *Pantoja-Lopez v. Elk Hill Farm*, No. 2006-SC-000213-WC, 2007 WL 189003 (January 25, 2007), our Supreme Court held, albeit in a different context, that a medical records review may constitute reasonable grounds upon which to base a decision regarding whether to terminate or deny benefits. Therein, a plaintiff seeking workers' compensation benefits appealed from an Administrative Law Judge's (ALJ) finding that his injury only resulted in permanent partial disability. The ALJ had based his decision, in part, on the findings of a paper review of the plaintiff's medical records. On appeal, the Supreme Court ruled that the ALJ was,

in fact, permitted to rely on the medical records review and that the decision was reasonable.

GEICO asserts that it essentially sits in the same position as the ALJ in *Pantoja-Lopez*, and, as such, it is similarly permitted to rely on medical record reviews to deny or terminate benefits. We disagree. The ALJ in Workers' Compensation disputes is an independent fact-finder. In contrast, GEICO, as the reparations obligor, is in no manner independent. Likewise, although characterized as a third-party medical consulting company, there can be no dispute that Integrity is retained by GEICO for the sole purpose of reviewing its insured's medical records. Not surprisingly, Appellants claim that of the two hundred patient files that were reviewed in the process of establishing the class for the instant lawsuit, there were no instances in which Integrity doctors found that that an insured's treatment continued to be reasonable and necessary. GEICO's unilateral decision to deny or terminate benefits based upon a paper review of an insured's medical records conducted by a firm it has retained simply cannot be considered to be analagous to the decision of an ALJ.

We likewise find no merit in GEICO's warning that to construe Kentucky's MVRA as prohibiting a reparations obligor from denying a claim on the basis of anything other than a court-ordered IME would lead to "absurd and unreasonable results." GEICO points out that Florida, which has similar MVRA provisions as Kentucky, has recognized that requiring an IME before denying payment of a medical bill is irrational. Specifically, GEICO cites to *Nationwide*

Mutual Fire Insurance Co. v. Southeast Diagnostics, *Inc*. 766 So.2d 229, 230-31 (Fl. App. 2000), wherein the Florida District Court of Appeals held,

> We can envision many instances in which a competent physician upon reviewing medical records could conclude without the benefit of a physical examination that a treatment or test was not "reasonable, related, or necessary." If we follow Southeast's reasoning to its logical conclusion, every time a treating physician to whom a PIP carrier has paid benefits either conducted a diagnostic test or referred an insured for diagnostic testing, no matter how unconventional or medically unsound, a physical examination would be required before the payment could be refused.

GEICO fails to recognize, however, that although Florida's MVRA contains a court-ordered IME provision similar to Kentucky's, it has a crucial distinction, namely, that it specifically states:

> An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains **a valid report** by a [] physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that the treatment was not reasonable, related, or necessary. [Emphasis added].

Florida Statutes Annotated 627.736(7)(a). As is evident by the above language, the Florida legislature has, as have some other legislatures across the country, amended its MVRA to permit reparations obligors, under specific guidelines, to terminate benefits based upon a medical report without a physical examination of the insured. Kentucky's legislature has not chosen to amend our statute accordingly.

We agree with Appellants that GEICO's fight should be in the legislature, not the courts. Although GEICO seeks to convince this Court that Kentucky's MVRA, as currently written, permits the interpretation they propose, Senate Bill 234 was introduced during the 2004 Kentucky Legislative session to amend KRS 304.39-020 to eliminate the presumption that medical bills submitted are reasonable; delete the requirement that a reparations obligor petition a court for an order directing an IME; and to authorize a reparations obligor "to submit any claim for benefits to an independent review, evaluation or opinion to determine issues such as reasonable medical necessity, appropriateness of treatment, whether charges are usual and customary, and whether the injury or loss is related to the accident." Senate Bill 234 did not pass during the 2004 session.

We are of the opinion that KRS 304.39-270(1) means exactly what it says – a reparations obligor who questions the veracity of an insured's medical bills may petition the court for an IME. The obligor also has the prior option of requesting that the insured voluntarily undergo an IME, which the insured may or may not agree to. However, if the obligor chooses to do neither, it must pay the claim, as medical bills are statutorily presumed to be reasonable and the burden is on the obligor to prove otherwise.

GEICO correctly argues that Kentucky's MVRA does not preclude medical records review as a form of investigation. Indeed, KRS 304.39-280 expressly authorizes a reparations obligor to obtain an insured's medical records and information in order to ascertain the nature and necessity of the claim. The fact

remains, however, that Kentucky's statutory framework does not permit a reparations obligor to deny or terminate benefits solely based upon such medical records. It would simply be untenable to hold that the words "may petition the court" in KRS 304.39-270(1) allows an obligor to bypass the IME requirements and simply deny or terminate benefits on its own accord. *See Shelter Mutual insurance Co. v. Askew*, 701 S.W.2d 139, 142 (Ky. App. 1985) ("[T]he provisions of the 'no-fault' statute do not authorize an insurer to unilaterally determine the extent of medical services its insured is entitled to receive, nor the amount which the insured is entitled to pay for such services."). As such, the trial court erred in granting summary judgment in favor of GEICO.

Finally, GEICO has filed a motion in this Court to cite supplemental authority – specifically the unpublished decision from the United States District Court for the Eastern District of Kentucky, *Risner v. State Farm Mutual Automobile Insurance Co.*, Civil Action No. 14-41-HRW, 2015 WL 3857092 (June 22, 2015). Therein the Court addressed the sole issue of whether or not attorney's fees and 18% interest applied to the plaintiff's claim for termination of no-fault benefits. The court specifically stated that the question of whether State Farm wrongfully denied payment of benefits was not before the court. Nevertheless, the court did note with respect to KRS 304.39-270(1),

> [W]hile an insurer "may" seek an order compelling an IME, there is no requirement to do so. As Defendant points out, if Plaintiff's suggestion was accurate, and a court-ordered IME was required in each and every instance, no matter suspect, spurious or clearly unrelated

> to an accident the expense may be, the result would be an absurdly overly burdened system of bureaucracy.

We would initially observe that the district court's statement was made without any citation to Kentucky authority or discussion of the purpose and intent of our MVRA. Further, we are not bound by a federal court's interpretation of state law. *Embs v. Pepsi–Cola Bottling Co.*, 528 S.W.2d 703, 705 (Ky. 1975). Rather, the approach taken by a federal court may be viewed as persuasive but not binding. *U.S., ex rel. U.S. Attorneys ex rel. Eastern, Western Districts of Kentucky v. Kentucky Bar Ass'n*, 439 S.W.3d 136, 147 (Ky. 2014). We do not find the District Court's unpublished decision persuasive on the issue herein.

For the reasons set forth herein, we reverse the order of the Jefferson Circuit Court granting summary judgment in favor of GEICO and we remand this matter for further proceedings consistent with this opinion.

ALL CONCUR.

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