IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

IN AND FOR NEW CASTLE COUNTY

TERESA TAYLOR,	)	
	)	
Plaintiff,	)	
	)	
v.	)	C.A. No. 11C-03-070 WCC
	)	
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,	)	
	)	
	)	
Defendant.	)	

Submitted: November 21, 2011
Decided: March 30, 2012

On Defendant's Limited Motion for Summary Judgment – **DENIED**

OPINION

Francis J. Jones, Jr., Esquire. Morris James LLP, 803 North Broom Street, Wilmington, DE 19806. Attorney for Plaintiff.

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CARPENTER, J.

Insurers must provide compensation for costs related to surgeries performed more than two years after an accident if an insured submits a doctor's verification that the surgery cannot be performed earlier. Plaintiff submitted such verification, but a change in the surgeon's schedule enabled her to undergo surgery within the two-year coverage period. The question before the Court is whether expenses related to that surgery which were incurred after the two-year period are covered under Plaintiff's PIP benefits.

BACKGROUND

Plaintiff Theresa Taylor was involved in an automobile accident on October 6, 2008. Defendant State Farm Mutual Automobile Insurance Company is Taylor's insurer. In accordance with 21 *Del. C.* § 2118(a)(2), State Farm is obligated to compensate Taylor for reasonable and necessary medical treatment related to the accident and incurred within two years from the date of the accident. In Taylor's case, this two-year coverage period began on October 6, 2008, and ended on October 6, 2010.

Near the end of her two-year period, Dr. Craig Morgan recommended Taylor undergo surgery to address pain in her shoulder. In order to obtain compensation for the surgery, related medical treatment, and lost wages, Taylor followed the statutory notice requirement in 21 *Del. C.* § 2118(a)(2)a.3 and

submitted to State Farm a letter from Dr. Morgan verifying that (1) the shoulder surgery was necessary; (2) it was impractical or impossible to perform the surgery before October 6, 2010; and (3) Taylor would likely incur medical expenses and lost wages after October 6, 2010 as a result of the surgery.

However, an unexpected opening in Dr. Morgan's schedule enabled Taylor to undergo surgery on September 29, 2010, a week before her two-year period ended. Taylor's follow-up treatments and the recovery process continued after her two-year period ended. She spent about $1,122 on follow-up appointments, prescription medication, medical equipment, and co-payments, and missed three weeks of work. These medical expenses and lost wages were incurred after October 6, 2010.

Taylor tried to obtain compensation for the related expenses but State Farm denied her claim. State Farm argues that the doctor's letter did not extend coverage for related medical treatment and lost wages beyond the two-year period because the surgery was not impractical or impossible to perform within two years of the accident as required by statute. Taylor subsequently initiated this suit for compensation for medical treatment and lost wages incurred after October 6, 2010. State Farm moves for partial summary judgment on this issue alone.[1]

[1] Taylor has also sued State Farm for compensation for the cost of her shoulder surgery. State Farm denies that it must compensate Taylor for the surgery because there is a material issue of fact as to the reasonableness, necessity, and proximate cause of Taylor's shoulder injuries. This issue, however, is not within the scope of the motion presently before the Court because the surgery occurred within the coverage period. The surgery is important in the foregoing analysis insomuch as its timing affects Taylor's rights to compensation for related medical treatment and lost wages.

STANDARD OF REVIEW

A party is entitled to summary judgment where there are no genuine issues of material fact.[2] The moving party bears the burden of showing that there are no genuine issues of material fact so that he is entitled to judgment as a matter of law.[3] The Court must view all factual inferences in the light most favorable to the non-moving party.[4] Summary judgment will not be granted if it appears that there is a material fact in dispute or that further inquiry into the facts would be appropriate.[5]

DISCUSSION

This case provides the Court the opportunity to clarify the requirements of 21 *Del. C.* § 2118(a)(2)a.3, a statute whose interpretation has been confused by amendments and conflicting case law. The parties do not dispute the facts in this case; their contentions focus on the requirements of 21 *Del. C.* § 2118(a)(2)a.3. The statute was last amended in 1982, and the current version of the statute reads differently than the previous version. However, Delaware courts have only interpreted the statute's previous version, or have interpreted the current version using an analytical framework predicated on the previous version. Until now, this

[2] Super. Ct. Civ. R. 56(c); *Wilmington Trust Co. v. Aetna*, 690 A.2d 914, 916 (Del. 1996).
[3] *Moore v. Sizemore*, 405 A.2d 679 (Del. 1979).
[4] *Alabi v. DHL Airways, Inc.*, 583 A.2d 1358, 1361 (Del. 1990).
[5] *Ebersole v. Lowengrub*, 180 A.2d 467, 570 (Del. Super. 1962), *rev'd in part on proc. grounds and aff'd in part*, 208 A.2d 495 (1965).

approach yielded results in harmony with the statute's legislative intent. Unfortunately, the same cannot be said in this case.

The Court must scrutinize the current version of 21 *Del. C.* § 2118(a)(2)a.3 to answer two specific questions: First, *what* must be impractical or impossible to perform within the two-year period—in other words, what necessary procedures or treatments trigger 21 *Del. C.* § 2118(a)(2)a.3—such that an insured is entitled to benefits after the two-year period? And second, *how* does an insured demonstrate that impracticality or impossibility? To answer these questions, the Court must review the statute's past and present interpretations.

1. Procedures or treatments that trigger 21 *Del. C.* § 2118(a)(2)a.3

The previous version of 21 *Del. C.* § 2118(a)(2)a.3 required insurers to cover the:

> [c]ost of dental or surgical procedures, medical expenses including related treatment and the net amount of lost earnings the necessity of which have been medically ascertained within 2 years from the date of the accident but which are impractical or impossible to perform during that period and as to which verification that such procedures or treatments will be necessary has been made in writing by a qualified medical practitioner within 2 years from the date of the accident.[6]

In *Kemske v. The Ohio Casualty Insurance Co.* the Superior Court analyzed this version of the statute to determine what exactly had to be necessary but

[6] *Carucci v. Van Dyke*, 394 A.2d 246, 248 (Del. Super. 1978).

impractical or impossible to perform within the two-year period.[7] The plaintiffs in *Kemske* notified their insurer that they would require further medical treatment beyond their two-year period but did not specify whether that medical treatment included surgical or dental procedures.[8] The insurer refused to compensate them for their medical treatment, arguing that 18 *Del. C.* § 2118(a)(2)a.3 covered only surgical and dental procedures.[9] The Superior Court disagreed. It wrote that the statute's language indicated insurers were required to provide compensation for treatment other than dental or surgical procedures which were necessary beyond the two-year period: "the necessity of which" referred to "dental or surgical procedures, medical expenses *including related treatment*" (emphasis added).[10]

In 1982 the statute was amended to its current version. The statute now provides:

> Where a qualified medical practitioner shall, within 2 years from the date of an accident, verify in writing that surgical or dental procedures will be necessary and are then medically ascertainable but impractical or impossible to perform during that 2-year period, the cost of such dental or surgical procedures, including expenses for related medical treatment, and the net amount of lost earnings lost in connection with such dental or surgical procedures shall be payable.[11]

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[7] 1981 WL 384363 (Del. Super. June 18, 1981).
[8] *Id.* at *1.
[9] *Id.*
[10] *Id.*
[11] 21 *Del. C.* § 2118(a)(2)a.3.

The Superior Court took note of this amendment in *Feingold v. Pennsylvania National Mutual Casualty Insurance Co.*[12] It stated that the statute no longer covered medical treatments necessary beyond two years from the date of the accident, and that "the only procedures covered beyond the two-year period are dental procedures and surgical procedures."[13] The Court went on to hold that an insured is entitled to compensation when she obtains "a diagnosis or recommended course of treatment" that is related to a surgical or dental procedure which cannot successfully be completed within the two-year period.[14]

The plain language of 21 *Del. C.* § 2118(a)(2)a.3 supports this Court's finding that compensation is due under the current version of the statute only when a doctor verifies that a surgical or dental procedure—not related medical treatment—is impractical or impossible to perform within two years of an accident. Once a doctor so verifies, the insurer must provide compensation for the cost of the surgical or dental procedures *and* for related medical treatment and lost earnings. Having determined that 21 *Del. C.* § 2118(a)(2)a.3 is only triggered when a doctor verifies that a surgical or dental procedure is impractical or

[12] 1991 WL 269885 (Del. Super. Nov. 19, 1991).
[13] *Id.* at *3.
[14] *Id.* at *4.

impossible to perform within the two-year period, the Court will now analyze the "impractical or impossible" requirement of the statute.

2. 21 *Del. C.* § 2118(a)(2)a.3 "impractical or impossible" requirement

a. Past interpretations of the "impractical or impossible" provision

The seminal case for interpreting the requirements of 21 *Del. C.* § 2118(a)(2)a.3 is *Carucci v. Van Dyke*.[15] Analyzing the previous version of the statute, the *Carucci* court held that the language of 21 *Del. C.* § 2118(a)(2)a.3 specified three qualifying factors which must be present for an insured to obtain coverage:

> (1) ascertainment of necessity before expiration of the 2-year period, (2) impracticality or impossibility of performing the procedures or treatment within the 2-year period and (3) written verification within the 2-year period that the procedures or treatment will be necessary.[16]

Carucci, however, was decided before the statute's amendments, and—as indicated in this opinion's preceding discussion—the current version of the statute is worded differently than the previous version.[17] Even so, courts have continued

[15] 394 A.2d 246 (Del. Super. 1978).
[16] *Id.* at 248.
[17] State Farm, therefore, misplaces its reliance on 21 *Del. C.* § 2118(a)(2)a.3's requirements as framed by *Carucci* for the contention that the statute is unambiguous and not subject to construction.

to cite *Carucci* when determining whether an insured is entitled to coverage beyond the two-year period.[18]

For example, the Superior Court cited *Carucci* when it first interpreted the current version of 21 *Del. C.* § 2118(a)(2)a.3 "impractical or impossible" provision in *Feingold*.[19] The plaintiff in *Feingold* began treatment for injuries she sustained in an accident over eighteen months after the date of the accident.[20] She timely submitted a doctor's written verification that her procedures were necessary but impractical or impossible to perform within the two-year coverage period.[21] The evidence suggested, however, that the necessary procedures could have been performed within the two-year period if the plaintiff had sought treatment earlier.[22] Based on this evidence, the insurer argued that the plaintiff's procedures were not, in fact, impossible or impractical to perform within the two-year period.[23]

The Superior Court rejected this argument, holding that:

> [A] party complies with the statute where he or she obtains a diagnosis or recommended course of treatment within the two-year period and *the doctor*

[18] *See, e.g. Feingold v. Pennsylvania Nat. Mut. Ins. Co.*, 1991 WL 269885, at *3 (Del. Super. Nov. 19, 1991), *Ashe v. State Farm Mut. Auto. Ins.* Co., 1995 WL 264645, at *2 (Del. Super. Apr. 17, 1995), *and Donophan v. Montgomery Mut. Ins. Co.*, 1996 WL 191197, at *4 (Del. Super. Mar. 18, 1996).
[19] *Feingold,* 1991 WL 269885.
[20] *Id*. at *1.
[21] *Id*.
[22] *See id*. at *1 (citing the doctor's verification note: "Since we have only been treating the patient since November 1989, it would be virtually impossible to expect the treatment to be completed within the period ending February 12, 1990.").
[23] *See id*. ("[D]efendant based its denial [of plaintiff's claim] on the ground Dr. Powell had not verified the treatment could not have taken place within two years from the date of the accident.").

timely verifies that such treatment cannot be successfully completed within that two-year period (emphasis added).[24]

Thus *Feinberg* further clarified the *Carucci* requirements by requiring *a doctor's verification* of the impracticality or impossibility of performing the procedures or treatment within the two-year period.[25]

The Court noted that requiring a doctor's verification accords with the public policy behind 21 *Del. C.* § 2118(a)(2)a.3. The purpose of the statute is to provide basic insurance coverage for all personal injury claims arising out of an automobile accident and to give the economic benefit of prompt payment to an injured party without awaiting protracted litigation.[26] The *Feingold* Court reasoned that demanding a factual inquiry as to whether a procedure truly could not have been performed within the two-year period would lead to protracted litigation among the parties and delayed payments to injured plaintiffs, thereby defeating the statute's purpose.[27]

The most recent case in which the Court reviewed the "impractical or impossible" requirement is *Ashe v. State Farm Mutual Automobile Insurance*

[24] *Id.* at *4.
[25] *Feingold*, 1991 WL 269885, at *4.
[26] *Id.*
[27] *Id.*

Co..[28] In *Ashe*, the plaintiff's doctor recommended a conservative course of treatment. As a result, the plaintiff needed a surgical procedure after the two-year coverage period ended.[29] The doctor timely verified this in writing and noted that the procedure was impractical or impossible to perform within two years of the accident.[30] The insurer refused to compensate the plaintiff for the procedure because, it argued, the procedure actually could have been performed within the two-year period.[31]

The Court ruled in favor of the plaintiff. It came to this decision after scrutinizing the language of 21 *Del. C.* § 2118(a)(2)a.3 and holding that "impractical" must be construed within the meaning of reasonable medical practice.[32] It found that the doctor's determination that the procedure was impractical to perform within the two-year period was conservative but nonetheless within the bounds of the reasonable practice of medicine.[33] The Court went on to note that it would not punish a plaintiff's decision to follow a doctor's reasonable medical advice to put off a particular procedure.[34]

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[28] 1995 WL 264645 (Del. Super. Apr. 17, 1995).
[29] *Id*. at *1.
[30] *Id*.
[31] *Id*. at *2.
[32] *Id*.
[33] *Ashe*, 1995 WL 264645, at *2.
[34] *Id*.

b. A modern interpretation of the "impractical or impossible" requirement

Ashe and *Feingold* reach the same conclusion, which, in essence, is that 21 *Del. C.* § 2118(a)(2)a.3 requires courts to defer to the expertise of medical professionals in determining whether a procedure is impractical or impossible to perform within the two-year coverage period. The statute's precise language reflects this conclusion. To break down the requirements of the current statute, much like the *Carucci* court broke down the requirements of the previous statute, 21 *Del. C.* § 2118(a)(2)a.3 requires a qualified medical practitioner, within two years from the date of an accident, to verify in writing that (1) surgical or dental procedures will be necessary; (2) at the time the verification is written, such surgical or dental procedures are medically ascertainable; and (3) at the time the verification is written, the medical practitioner determines that such surgical or dental procedures are impractical or impossible to perform within the two-year period. Interpreted this way, the statute precludes courts from engaging in retrospective speculation as to whether an insured could or should have undergone a procedure within two years of an accident. Such speculation, as noted in *Feinberg*, would lead to protracted litigation, and—as noted in *Ashe*—would impinge on doctors' informed recommendations for their patients' treatment.

Applying the requirements of the current version 21 *Del. C.* § 2118(a)(2)a.3 to the instant case, the Court finds that Taylor is entitled to compensation for her surgery-related expenses and lost wages that were incurred after the two-year period. For the purposes of this limited motion, the Court will assume that Taylor's shoulder surgery was necessary and was medically ascertainable, which satisfies the statute's first and second requirements. Taylor satisfies the third requirement of 21 *Del. C.* § 2118(a)(2)a.3 because, at the time of his written verification, Dr. Morgan, a well-respected surgeon, determined her surgery would be impractical or impossible to perform before October 6, 2010.

As in *Feinberg* and *Ashe*, the Court will defer to the doctor's reasoning as to why the surgery was impractical or impossible to perform within the two-year period, so long as that reasoning betrays no overt signs of dishonesty, irrationality, or disregard for the patient. No such signs exist here. Taken in the light most favorable to Taylor, the evidence shows that Dr. Morgan honestly believed, at the time he submitted his written verification, that his schedule could not accommodate her surgery with only a few weeks' notice.[35] The Court finds nothing suspicious about this. To the extent State Farm questions the timing of Taylor's decision to seek care for her shoulder, and that decision's effect on Dr.

[35] Dr. Morgan submitted his written verification of the necessity of Taylor's surgery on September 17, 2010. Taylor's two-year period ended on October 6, 2010.

Morgan's ability to perform the surgery within the two-year period, the Court reiterates the *Feinberg* holding: these issues are beyond the ken of the Court's inquiry under 21 *Del. C.* § 2118(a)(2)a.3.

The Court's holding aligns with principles of statutory interpretation in general. Statutes must be interpreted to give full effect to all of the pertinent statutory language.[36] Under 21 *Del. C.* § 2118(a)(2)a.3 doctors must verify "that surgical or dental procedures will be necessary and are *then* medically ascertainable but impractical or impossible to perform" in the two-year period (emphasis added). The legislature's inclusion of the word "then" signifies its intent that a doctor's conclusions be anchored to a particular moment on the statutory timeline, specifically, the moment when he verifies in writing the injury's necessity, medical ascertainment, and impracticality or impossibility to perform. To find that an unanticipated opening in a surgeon's busy schedule will foreclose coverage is simply inconsistent with common sense and would clearly frustrate the statute's legislative intent. To argue as much demonstrates a lack of good judgment by the insurance carrier.

[36] *Nationwide Ins. Co. v. Graham*, 451 A.2d 832, 834 (Del. 1982) ("Any interpretation of the statute must give full effect to all of the pertinent statutory language and produce the most consistent and harmonious result under the wording of the section.").

The Court's holding also aligns with principles of statutory interpretation with regards to insurance statutes in particular. These must be interpreted liberally to avoid a result contrary to the statute's purpose.[37] The purpose of 21 *Del. C.* § 2118(a)(2)a.3 is to assure prompt payment to injured parties for medical expenses and lost earnings.[38] If the Court denies Taylor's claim on the basis that she took advantage of a fortuitous opening in Dr. Morgan's schedule, future plaintiffs in similar situations might protract their treatment beyond two years and deem it better to delay necessary medical treatment instead of running the risk that their carrier would cut off their PIP benefits. This result is contrary to the statute's purpose. To the extent the Court has misinterpreted the legislative intent behind 21 *Del. C.* § 2118(a)(2)a.3—and the Court doubts that it has—its misinterpretation is in any event supported by precedent: "If the court should err in determining the meaning of an insurance policy provision or the legislative intent of a statute . . . error should be in favor of coverage for the insured."[39]

CONCLUSION

The Court finds that the current version of 21 *Del. C.* § 2118(a)(2)a.3 entitles Taylor, if she meets all other statutory requirements, to compensation for

[37] *Wyant v. O'Bryan*, 1999 WL 33116507, at *2 (Del. Super. Dec. 28, 1999) ("When construing an insurance statute, courts must apply a liberal interpretation to the statute and avoid a result which is contrary to the purpose of the statute.").
[38] *DeVincentis v. Maryland Casualty Co.*, 325 A.2d 610, 612 (Del. Super. 1974) ("One of the primary objectives of the no-fault insurance law was to assure prompt payment to an injured party for medical expenses and lost earnings and property damage.").
[39] *Wyant*, 1999 WL 33116507, at *2 (internal quotations omitted).

the cost of the surgery, related medical treatment, and lost wages. The Court will defer to a doctor's written, good faith verification that a surgical procedure is impractical or impossible to perform within the two-year period, and when the doctor so verifies, the two-year PIP limitation will be extended to cover reasonably related medical treatment and wages lost after the two-year period.[40] The fact that, after the doctor's verification, the surgery was unexpectedly scheduled before the two year coverage period ended will have no effect on the PIP benefits available to cover the costs of related medical treatment and lost wages incurred thereafter.

IT IS SO ORDERED.

/s/ William C. Carpenter, Jr.
Judge William C. Carpenter, Jr.

[40] Subject to 21 *Del. C.* § 2118(a)(2)a.3's 90-day limitation on the period for which an insured may recover lost wages after the two-year period.