STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

HUBERT MERAYO, M.D.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 09-0018
	)	
DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF WORKERS' COMPENSATION, OFFICE OF MEDICAL SERVICES,	)	
	)	
Respondent.	)	
_____	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on February 23, 2009, by video teleconference, with the parties appearing in Miami, Florida, before Patricia M. Hart, a duly-designated Administrative Law Judge of the Division of Administrative Hearings, who presided in Tallahassee, Florida.

APPEARANCES

For Petitioner: Edward F. DeVarona, Esquire[1]
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For Respondent: Mari H. McCully, Esquire
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Division of Workers' Compensation
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STATEMENT OF THE ISSUE

Whether the Petitioner is entitled to reimbursement for charges billed to a workers' compensation insurance carrier for medical services rendered to an injured employee/claimant, pursuant to Section 440.13, Florida Statutes (2007).[2]

PRELIMINARY STATEMENT

In a Workers' Compensation Medical Services Reimbursement Dispute Determination ("Determination") dated November 13, 2008, the Department of Financial Services, Division of Workers' Compensation, Office of Medical Services ("Department"), notified Dr. Humberto Merayo, M.D., that the Department had determined that Dr. Merayo was not entitled to reimbursement from Sedgwick Claims Management Services ("Sedgwick CMS"), a workers' compensation insurance carrier, for psychiatric medical services rendered to M.P., a workers' compensation claimant ("Claimant"), on April 11, 2007; August 21, 2007; October 16, 2007; December 11, 2007; and January 22, 2008. In the Determination, the Department concluded that the medical services provided on those dates constituted over-utilization, and that payment to Dr. Merayo for services performed on those dates was properly disallowed by Sedgwick CMS for these dates of service. The Department did, however, find that the medical services provided on September 18, 2007, for which Sedgwick CMS had also disallowed payment, did not constitute over-utilization

and that Dr. Merayo was entitled to reimbursement for those services.

Dr. Merayo timely filed a Petition for Administrative Hearing with respect to the Determination, and the Department transmitted the matter to the Division of Administrative Hearings for assignment of an administrative law judge. On January 16, 2009, the Department filed a Motion for Notice and Opportunity to Join an Indispensable Party, in which it identified Sedgwick CMS as a person whose substantial interests would be determined in the instant case. An Order Requiring Notice to Indispensable Party was entered on February 6, 2009, and, on February 9, 2009, the Department sent a Notice of Litigation to Sedgwick CMS. Sedgwick did not file a petition to intervene and is, therefore, not a party to these proceedings, although it did send an attorney to observe the final hearing. Pursuant to notice, the final hearing was held on February 23, 2009.

On February 20, 2009, Dr. Merayo and the Department filed a Joint Pre-Hearing Stipulation, which included a list of witnesses and exhibits, as well as an extensive recitation of facts to which the parties stipulated. At the hearing, Dr. Merayo testified in his own behalf but offered no exhibits. The Department presented the testimony of Welby Cox-Myers and Anna Ohlson; Respondent's Exhibits 1 and 3 through 7 were

offered and received into evidence. Mr. DeVarona, who, as noted in endnote 1, appeared at the final hearing without having filed a notice of appearance as required by Florida Administrative Code Rule 28-106.105 and who apparently was not involved in preparing the Joint Pre-Hearing Stipulation, entered a hearsay objection to Petitioner's Exhibits 3 and 6 pursuant to Section 120.57(1)(c), Florida Statutes ("Hearsay evidence may be used for the purpose of supplementing or explaining other evidence, but it shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions.").

Petitioner's Exhibit 3 consists of the transmittal letter, Statement, and "EMA Report" of Norman D. Guthrie, M.D., an expert medical advisor ("EMA") appointed by the Department; Petitioner's Exhibit 6 consists of documents submitted to the Department by Sedgwick CMS. At the final hearing, the undersigned accepted Petitioner's Exhibits 3 and 6 subject to the limitation on the use of hearsay in Section 120.57(1)(c), Florida Statutes, and gave the Department leave to depose Dr. Guthrie and file the deposition transcript in lieu of Dr. Guthrie's live testimony, as a late-filed exhibit.

On March 6, 2009, the Department filed a Motion for Reconsideration Regarding Admission of "EMA Report"; Dr. Merayo filed a response in opposition to the motion. After a

telephonic hearing was held on the motion, the undersigned reversed her ruling at the final hearing and, on March 17, 2009, entered an Order Granting Motion to Reconsider Ruling; Accepting EMA Report in Lieu of Live Testimony; and Granting Leave to Petitioner to Depose EMA. The Order contains a full explanation of the rationale for the decision on reconsideration, but, in brief, the rationale for the ruling is as follows: Dr. Guthrie was identified in the parties' Joint Pre-Hearing Stipulation as a witness in the proceeding, appearing "via EMA Report" and, on this basis, the EMA Report was received into evidence as non-hearsay evidence.[3] Even though he was given leave in the March 17, 2009, Order to depose Dr. Guthrie regarding the EMA Report, he apparently did not do so since no deposition transcript has been filed with the Division of Administrative Hearings.

The one-volume transcript of the proceedings was filed with the Division of Administrative Hearings on March 12, 2009, and the parties timely filed proposed findings of fact and conclusions of law. On April 3, 2009, the day after Dr. Merayo filed his proposed findings of fact and conclusions of law, the Department filed a Motion to Strike Petitioner's Proposed Findings of Law and Fact or Alternative Relief. In the motion, the Department pointed out alleged errors of fact, statements with which the Department disagrees, and statements allegedly

not supported by the record contained in Dr. Merayo's proposed findings of fact and conclusions of law. The Department requested that all such errors and statements be stricken, or, in the alternative, that the Department's motion be accepted as a response to Dr. Merayo's submittal.

It is the responsibility of the undersigned to review the record of a proceeding and to make findings of fact and conclusions of law based exclusively on that record. Although the undersigned always considers the proposed findings of fact and conclusions of law submitted by the parties, any proposal that is not supported by the record is rejected as a matter of course. It is, therefore, unnecessary to strike portions of a party's proposals, and the Department's Motion to Strike Petitioner's Proposed Findings of Law and Fact is denied.

A response to a party's proposed findings of fact and conclusions of law is not expressly permitted by statute or rule, although one may be permitted by order of the administrative law judge, upon a showing of good cause. The Department's motion does not establish good cause for permitting a response to Dr. Merayo's Proposed Findings of Law and Fact. The Department's Proposed Recommended Order sufficiently states the Department's position on the issue presented in this case, and further argument would not assist the undersigned in the preparation of the Recommended Order. The Department's

alternative request that its motion be accepted as a response to Dr. Merayo's Proposed Findings of Law and Fact is denied. The proposed findings of fact and conclusions of law of both parties have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, including the pertinent portions of the stipulations of fact contained in Section VI of the Joint Pre-Hearing Stipulation, the following findings of fact are made:

1. The Department is the state agency responsible for resolving reimbursement disputes involving health care providers and workers' compensation insurance carriers and employers ("employer/carrier"). See §§ 440.13(7) and (11)(c), Fla. Stat.[4]

2. The dispute resolution process is initiated when a health care provider files a petition with the Department contesting the decision of an employer/carrier to disallow or adjust payment to the health care provider for services provided to an injured worker/claimant. The petition must be accompanied by documentation supporting the allegations in the petition; if the documentation is not complete, the Department is to dismiss the petition. See § 440.13(7)(a), Fla. Stat. The employer/carrier is then required to submit a response to the

petition to the Department, together with all documentation supporting its decision to disallow or adjust the health care provider's reimbursement requests. See § 440.13(7)(b), Fla. Stat.

3. After review of the documentation submitted by the provider and the employer/carrier, the Department must determine whether the employer/carrier properly disallowed or adjusted payment to the health care provider, and it must provide a written determination setting out its decision. See § 440.13(7)(c), Fla. Stat.

Procedure followed by the Department in resolving reimbursement dispute at issue in this proceeding

4. The reimbursement dispute at issue herein arose after Sedgwick CMS, a workers' compensation insurance carrier, issued through its agent an Explanation of Bill Review and a First Notice of Disallowance dated April 16, 2008, notifying Dr. Merayo of its decision to disallow reimbursement for medical services he provided to the Claimant on April 11, 2007, August 21, 2007, September 18, 2007, October 16, 2007, December 11, 2007, and January 22, 2008, on the grounds that there had been over-utilization; specifically, Sedgwick CMS stated that it had based its decision with regard to those dates on its conclusion that that the treatment Dr. Merayo had

provided the Claimant on those dates was excessive and/or not medically necessary.

5. After receiving the First Notice of Disallowance from Sedgwick CMS, Dr. Merayo initiated the dispute resolution process when he timely filed with the Department a Petition for Resolution of Reimbursement Dispute ("Reimbursement Dispute Petition") dated May 16, 2008. Dr. Merayo requested in the Reimbursement Dispute Petition that the Department resolve the dispute between him and Sedgwick CMS regarding reimbursement for psychiatric services that he rendered to the Claimant on the dates identified in the First Notice of Disallowance. Dr. Merayo attached to the Reimbursement Dispute Petition documentation including medical records for the Claimant, and Sedgwick CMS timely submitted a response to the Reimbursement Dispute Petition, together with extensive medical and other records related to the Claimant.

6. Among the records submitted to the Department by Sedgwick CMS were reports of two psychiatric independent medical examinations of the Claimant, both conducted in 1999, and peer review reports completed by three psychiatrists in December 2007, January 2008, and February 2008. Department personnel reviewed the documents submitted by Dr. Merayo and by Sedgwick CMS, including the two independent medical examination reports and the three peer review reports.

7. After reviewing the documentation, Department personnel determined that, because there was no consensus among the physicians conducting the peer reviews regarding the frequency, duration, or intensity of services for the medical management of the Claimant's psychiatric needs, an EMA should review the documentation and provide guidance to Department personnel in resolving the reimbursement dispute.

8. As authorized by Section 440.13(9)(f), Florida Statutes, the Department referred the matter to Dr. Guthrie, a psychiatrist certified by the Department as an EMA pursuant to Section 440.13(9)(a), Florida Statutes, and requested that he prepare a report regarding the medical necessity for the treatment Dr. Merayo provided the Claimant on the dates for which Sedgwick CMS had denied reimbursement. The Department indicated that all documents contained in its records would be provided to Dr. Guthrie and that, if he required additional documentation, he should immediately contact the Department. Dr. Guthrie submitted his report to the Department on November 3, 2008.

9. The Department based its Determination that there was over-utilization of Dr. Merayo's medical services on April 11, 2007, August 21, 2007, October 16, 2007, December 11, 2007, and January 22, 2008, on a review of the documentation submitted, "specifically the carrier-obtained peer review report

prepared by Dr. Sinakin [sic] and response from the Expert Medical Advisor." It based its decision that there was no over-utilization by Dr. Merayo on September 18, 2007, on Dr. Guthrie's EMA Report.

Claimant's relevant medical history and independent medical examination reports prior to her treatment by Dr. Merayo[5]

10. The Claimant suffered injuries to her back as a result of an employment-related accident on December 29, 1997. Sedgwick CMS authorized psychiatric evaluation and treatment for the Claimant in April 1999, which she received from the Center for Occupational Psychiatry of Florida. The Claimant was diagnosed by Dr. Noel Delgadillo in 1999 as suffering from adjustment disorder and disorder of chronic pain, and he recommended treatment, with maximum medical improvement expected within six months. The Claimant received psychiatric medical services involving group and individual therapy and medication prescriptions and management from Dr. Delgadillo's associate, Dr. Angel Diaz, and employees of the Center for Occupational Psychiatry of Florida.

11. Sedgwick CMS ordered a psychiatric independent medical examination of the Claimant, which was conducted on July 23, 1999, by Dr. Marilu Sabas. Dr. Sabas diagnosed the Claimant as suffering from "adjustment disorder," and she opined that the Claimant's symptoms were "the direct result of the

accident . . . and the subsequent physical pain and emotional stress."

12. On October 1, 1999, Dr. Diaz determined that the Claimant reached maximum medical improvement and assigned a permanent impairment rating of five percent.

13. Sedgwick CMS ordered a second independent medical examination, which was conducted on October 20, 1999, by Dr. Anastasio Castiello. In Dr. Castiello's opinion, the Claimant "presented the clinical picture of an individual manifesting the exaggerated elements of a personality disorder and her actual representation is tailored to the circumstances of the litigation." Dr. Castiello concluded that, "under the circumstances, a recommendation for further psychiatric intervention is not clinically warranted."

14. Sedgwick CMS continued to authorize Dr. Diaz to provide psychiatric evaluation and treatment in the form of group and individual psychotherapy, together with medication prescriptions and management until December 2004, when Sedgwick CMS authorized Dr. Merayo to provide psychiatric treatment to the Claimant.

Dr. Merayo's treatment of the Claimant

15. Dr. Merayo is a board-certified psychiatrist who has treated patients suffering from work-related injuries for more than 10 years.

16. In December 2004, Dr. Merayo diagnosed the Claimant as suffering from major depressive disorder, recurrent and severe, without psychotic features, and he recommended continued group and individual psychotherapy, which was authorized by Sedgwick CMS and which she received from the Merayo Medical Arts Group. Dr. Merayo initiated an aggressive medication treatment regimen for the Claimant and conducted individual psychotherapy sessions. The Claimant also attended group therapy sessions led by members of Dr. Merayo's group.

17. On August 23, 2005, Dr. Merayo opined that the Claimant had reached maximum medical improvement, and he assigned her a permanent impairment rating of 15 percent. Dr. Merayo also opined that the Claimant was unable to work due to her compensable injury.

18. In 2006, Dr. Merayo conducted nine individual psychotherapy sessions, approximately one every six weeks, and the Claimant also participated in 30 group therapy sessions.

19. At the end of 2006, Dr. Merayo was notified by Sedgwick CMS that it would not authorize further group therapy sessions, and, beginning in January 2007, the Claimant received only individual psychotherapy and medication management reviews from Dr. Merayo.

20. Dr. Merayo conducted monthly individual psychotherapy sessions with the Claimant in 2007, for a total of 12 sessions,

and in January, February, and March 2008. Sedgwick CMS paid Dr. Merayo for the individual psychotherapy sessions he conducted in January, February, March, May, June, July, and November 2007 and February 2008. Sedgwick CMS did, however, advise Dr. Merayo in the April 16, 2008, First Notice of Disallowance that it considered the services provided on July 18, 2007, November 13, 2007, and February 22, 2008, to be excessive, not reasonable, and medically unnecessary. The treatment Dr. Merayo provided the Claimant on the dates at issue herein was no different from the treatment provided on the dates for which Dr. Merayo received reimbursement.

21. On the dates at issue herein, Dr. Merayo documented his individual psychotherapy sessions with the Claimant on a form entitled "Progress Notes," which consisted primarily of a checklist of items that he completed during the sessions, including observations on such things as appearance, behavior, attitude toward examiner, speech, mood, affect, perceptions, thought process, thought content, orientation, and the type of therapy provided. The form had blank spaces for Dr. Merayo to enter the Claimant's subjective complaints, stressors, and functioning, testing done, side effects of medication, and referrals and interventions.

22. Dr. Merayo's notes of the Claimant's individual psychotherapy sessions on the dates at issue indicate that the

Claimant consistently complained of chronic pain in her back and legs, of anxiety, and of difficulty sleeping.[6] The Claimant's diagnosis of major depression, recurrent and severe, remained the same throughout the time period at issue, and, at each psychotherapy session, Dr. Merayo prescribed medications for insomnia, depression, and anxiety.

23. Specifically, Dr. Merayo prescribed Restoril, Wellbutrin, Effexor, and Klonopin at the Claimant's psychotherapy sessions on April 11, 2007, and on August 12, 2007. As discussed in more detail below, Dr. Merayo substituted Ambien and Vistaril for the Restoril on October 16, 2007,[7] and he prescribed these two new medications, together with Wellbutrin, Effexor, and Klonopin, in December 2007 and January 2008.[8] On December 11, 2007, Dr. Merayo increased the dosage of Wellbutrin, an antidepressant, from 150 milligrams to 300 milligrams because the Claimant was exhibiting increasing depression.

24. In Dr. Merayo's opinion, prescribing only a month's supply of medications at each monthly visit was the safest procedure for the Claimant. If a patient is taking only one antidepressant and is otherwise doing well, it is appropriate to conduct a medication review for that patient every three months. The Claimant's case was complex, however, because she was taking four or five medications at any given time, including two

benzodiazepines and two antidepressants. In Dr. Merayo's medical judgment, even though there was no indication that the Claimant misused the medications or had any side effects, it was necessary that he conduct medication management reviews for the Claimant every month and prescribe only a 30-day supply of medications because of the number and nature of the medications.

25. Dr. Merayo noted in his Progress Notes on the dates at issue that the Claimant's ego defenses were weak and that her recent memory was not very sharp. Dr. Merayo was particularly concerned about the Claimant because her weak ego defenses indicated possible regression.

26. At the Claimant's psychotherapy session on October 16, 2007, Dr. Merayo decided to substitute Ambien and Vistaril for Restoril because he was concerned about the possible addictive effects of Restoril and because of his concern that Restoril was related to the Claimant's declining recent memory. Dr. Merayo also noted in his Progress Notes for the October 16, 2007, psychotherapy session that the Claimant complained of pain all over her body and expressed frustration that she was not getting any better.

27. The Claimant's treatment plan, consisting of cognitive behavior therapy, supportive therapy, coping skills, and anxiety control, remained unchanged on the dates at issue, and Dr. Merayo indicated in the Progress Notes for each of the

psychotherapy sessions that the Claimant's condition was the same. On all of the dates at issue except for October 16, 2007, Dr. Merayo checked the box on the Progress Notes specifying that the Claimant's progress toward the treatment goals was between 30 percent and 40 percent; on October 16, 2007, Dr. Merayo checked the box on the Progress Notes specifying that the Claimant's progress toward the treatment goals was between 20 percent and 30 percent. There are, however, no treatment goals stated in any of the Progress Notes.

28. Additionally, the observations Dr. Merayo recorded on the Progress Notes for almost all of the dates at issue indicated that the Claimant's appearance was casual[9]; her behavior was quiet and needy; her eye contact was fair; her attitude toward Dr. Merayo was cooperative; her speech was spontaneous; her mood was depressed and anxious; her affect was labile; her thought process was goal oriented; her thought content was logical[10]; she was not suicidal; her orientation was "OK"; her consciousness was alert; her sleep was "OK"; her appetite was "OK"; her libido was low; her concentration was poor; her attention was good; her judgment was fair; and her coping skills were fair.

29. In Dr. Merayo's opinion, the appropriate treatment for the Claimant, or any patient with her diagnosis, is medication management and psychotherapy. Dr. Merayo described the Claimant

as a person who is in need of psychotherapy because of her diagnosis and explained that she needed the 45 minutes allotted for each of her monthly psychotherapy sessions on the dates at issue. In Dr. Merayo's opinion, the Claimant was regressing during the time period covering the dates at issue and required psychotherapeutic intervention for chronic mental illness to avoid moving from major depression to exhibiting psychotic features.

30. In his years of medical practice, Dr. Merayo has observed that patients having the Claimant's diagnosis and amount of medication often end up in the hospital if they go for too long a period without being seen. Dr. Merayo acknowledged, however, that many patients probably do not need the level of service he provided to the Claimant after reaching maximum medical improvement and that most patients could be adequately treated with 25-minute psychotherapy sessions conducted less frequently than those he conducted with the Claimant.

31. In Dr. Merayo's opinion as a board-certified psychiatrist, the quality, quantity, and duration of medical care that he provided to the Claimant on each of the dates at issue were medically reasonable and necessary in order to prevent the Claimant from regressing and to provide her with psychotherapy that she needed and that provided her relief. He was aware of no guidelines setting forth the frequency and

intensity of psychiatric services to be provided to a claimant after a declaration of maximum medical improvement except the sound medical judgment of the health care provider.

32. Notwithstanding the reimbursement dispute at issue herein, Dr. Merayo was authorized by Sedgwick CMS to provide psychiatric treatment to the Claimant at the time of the final hearing.

EMA Report

33. Dr. Guthrie was appointed by the Department as an expert medical advisor to render an opinion as to the medical necessity/over-utilization issues presented in the reimbursement dispute between Sedgwick CMS and Dr. Merayo. In its Order Referring Matter for Expert Medical Advisor Review, the Department requested that Dr. Guthrie assist in resolving the reimbursement dispute by specifically answering the following question:

> Whether the type, intensity and duration of the evaluation and treatment provided on April 11, 2007, August 21, 2007, September 18, 2007, October 16, 2007, December 11, 2007, and January 22, 2008, are consistent with the medically necessary standard of care for the clinical problem(s) documented by the Petitioner in the medical record of the Injured Employee? Please identify the standard(s) of care that support the opinion provided.

34. Dr. Guthrie submitted his EMA Report on November 3, 2008, and he listed the documents he reviewed in an appendix to

the report. The documents listed by Dr. Guthrie were all those submitted to the Department by Sedgwick CMS and by Dr. Merayo regarding the medical services provided to the Claimant since the date of her injury in 1997. Dr. Guthrie did not examine the Claimant in the course of preparing his EMA Report.

35. In his report, Dr. Guthrie opined "within a reasonable degree of medical certainty" that reimbursement for the psychotherapy sessions conducted by Dr. Merayo with the Claimant on April 11, 2007, August 21, 2007, September 18, 2007, October 16, 2007, December 11, 2007, and January 22, 2008, should be disallowed by Sedgwick CMS because these psychotherapy sessions "would not be expected to be necessary."[11] Dr. Guthrie noted, however, that, in his opinion, Sedgwick CMS should reimburse Dr. Merayo for the psychotherapy session conducted September 18, 2007, because "if all three of those visits [August, September, and October] are disallowed, then there would be a four month gap from July to November without adequate follow-up."[12]

36. Dr. Guthrie stated the basis for his opinion in pertinent part as follows:

> Typically, following a declaration of maximum medical improvement, it is anticipated that the frequency and to some degree, the intensity of therapeutic treatments would gradually decrease with the ultimate expectation that therapeutic follow-ups (which might include simply

> medication management or at times, might necessarily include medication management plus individual therapy of a supportive nature) would be necessary on an every two to three month basis, requiring at most, four to six such appointments per year.
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> * * *
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> Given what would be considered a more typical need to treatment following a declaration of maximum medical improvement, it would be anticipated that during the year 2007, there would typically need to be four follow-up appointments unless some extraordinary situation developed. No such extraordinary situation is discernable from Dr. Merayo's records.

37. Dr. Guthrie summarized his opinion as follows:

> Therefore, given the expectation of follow-up care requiring four to at most six appointments per year subsequent to an [sic] maximum medical improvement declaration, it is my opinion, within a reasonable degree of medical certainty, that Dr. Merayo's continued monthly appointments of forty-five minutes duration suggest a pattern of over-utilization of services, ...[13]

Dr. Guthrie also observed:

> From the clinical status of the claimant/patient indicated in Dr. Merayo's notes, it is clear that she has continued to struggle emotionally and with chronic pain despite aggressive treatment provided by Dr. Merayo. It is quite possible that his pattern of over-utilization has been in an attempt to assist an ill patient; however, given his declaration of maximum medical improvement on August 23, 2005, we are left with no other conclusion than a pattern of over-utilization.

Summary

38. The evidence presented by Dr. Merayo is sufficient to establish with the requisite degree of certainty that he should be reimbursed for medical services he provided the Claimant on April 11, 2007; August 21, 2007; October 16, 2007; December 11, 2007; and January 22, 2008. For reasons discussed in more detail below in the Conclusions of Law, the opinions of Dr. Merayo and Dr. Guthrie are the only evidence presented on which a determination of the medical necessity of the Claimant's monthly psychotherapy and medical management sessions with Dr. Merayo can be based. After consideration of all of the creditable evidence, Dr. Merayo's opinion is accepted as more persuasive and more grounded in the medical needs of the Claimant than the opinion of Dr. Guthrie.

39. Dr. Guthrie's opinion was not based on an articulated "medically necessary standard of care for the clinical problem(s) documented by the Petitioner in the medical record of the Injured Employee," as required by the Department when it referred the reimbursement dispute to Dr. Guthrie,[14] nor did Dr. Guthrie identify an established standard of care for psychiatric treatment of a patient with problems similar to the Claimant's. Rather, Dr. Guthrie's opinion was based on the "expectation" that, after a patient is found to have reached maximum medical improvement, the number of psychotherapy and

medication management sessions would decrease to a maximum of four to six sessions per year, at a frequency of once every two to three months. In reaching his opinion regarding the frequency of psychotherapy and medication management review sessions that Dr. Merayo should have provided the Claimant, Dr. Guthrie imposed a standard that reflected "a more typical need" for treatment after maximum medical improvement of four sessions annually, but he never refers to the source of this standard of "typical need."

40. In addition, there is only one reference to the medical necessity of monthly treatments for the Claimant, given her clinical problems and the complexity of her medications, in the Conclusion and Opinion section of Dr. Guthrie's EMA report. In that reference, Dr. Guthrie acknowledged that the Claimant continued to struggle with emotional issues and chronic pain and that the frequency of Dr. Merayo's psychotherapy sessions with the Claimant may have been "in an attempt to assist an ill patient."[15] Nonetheless, because of the "expectation" regarding the frequency of treatment after a declaration of maximum medical improvement to which he referred in his report, Dr. Guthrie found that, regardless of the Claimant's need for treatment, he "is left with no other conclusion than a pattern of over-utilization" based solely on Dr. Merayo's having

declared that the Claimant attained maximum medical improvement in August 2005.[16]

41. In the absence of reference by Dr. Guthrie to an established practice parameter, a protocol of treatment, or a standard of care for a psychiatrist treating a patient with a diagnosis, symptoms, and medications similar to those of the Claimant to support the opinion expressed in his EMA report, the opinion expressed in Dr. Guthrie's EMA Report is rejected. Dr. Merayo's testimony that the frequency and duration of his psychotherapy and medication management review sessions with the Claimant were, in his medical judgment, medically necessary to avoid deterioration of the Claimant's mental state and her possible lapse into psychotic features is accepted.

CONCLUSIONS OF LAW

42. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2008).

Statutory scheme relating to payment of health care providers under Chapter 440, Florida Statutes.

43. Section 440.13, Florida Statutes, governs the provision of medical services and supplies to injured workers covered by Florida's workers' compensation laws. Section 440.13(2)(a), Florida Statutes, requires an employer,

usually, as in this case, through a workers' compensation insurance carrier, to provide "medically necessary remedial treatment, care, and attendance" to an injured worker. Section 440.13(14)(a), Florida Statutes, provides that an employer/carrier need only pay for medical services rendered by "a health care provider certified and authorized to provide remedial treatment, care, or attendance" under Chapter 440, Florida Statutes, and notes that health care "providers have recourse against the employer or carrier for payment for services rendered in accordance with this chapter."

44. Carriers are required in Section 440.13(6), Florida Statutes, to

> review all bills, invoices, and other claims for payment submitted by health care providers in order to identify overutilization and billing errors, including compliance with practice parameters and protocols of treatment established in accordance with this chapter, and may hire peer review consultants or conduct independent medical evaluations. Such consultants, including peer review organizations, are immune from liability in the execution of their functions under this subsection to the extent provided in s. 766.101. If a carrier finds that overutilization of medical services or a billing error has occurred, or there is a violation of the practice parameters and protocols of treatment established in accordance with this chapter, it must disallow or adjust payment for such services or error without order of a judge of compensation claims or the department, if the carrier, in making its determination,

> has complied with this section and rules adopted by the department.

Such reviews are referred to as utilization reviews, and the statute contemplates that the decision by an employer/carrier to disallow or adjust payment to health care providers, if reached in compliance with the governing statutes and rules, is self-executing.[17]

45. As set forth in the findings of fact herein, Sedgwick CMS determined that the services Dr. Merayo provided to the Claimant on the dates at issue constituted "overutilization and/or inappropriate utilization since the treatment has been excessive and not medically necessary."[18] It based this determination on reports submitted by its medical consultants, including the three peer review reports it received in late 2007 and early 2008.

46. The Legislature has provided a means by which a health care provider can contest an employer/carrier's decision to disallow or adjust payment for medical services because of over-utilization.[19] Section 440.13(7), Florida Statutes, permits a health care provider to petition the Department to resolve the reimbursement dispute and provides as follows:

> (a) Any health care provider, carrier, or employer who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 30 days after receipt of notice of disallowance or adjustment of payment,

petition the department to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a petitioner to submit such documentation to the department results in dismissal of the petition.[20]

(b) The carrier must submit to the department within 10 days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to timely submit the requested documentation to the department within 10 days constitutes a waiver of all objections to the petition.

(c) Within 60 days after receipt of all documentation, the department must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The department must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, practice parameters, and protocols of treatment, in rendering its determination.

(d) If the department finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the health care provider, facility, insurer, or employer within 30 days, subject to the penalties provided in this subsection.

(e) The department shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a petitioner and expanding the timetable for rendering a determination upon a consolidated petition.

> (f) Any carrier that engages in a pattern or practice of arbitrarily or unreasonably disallowing or reducing payments to health care providers may be subject to one or more of the following penalties imposed by the department:
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> 1. Repayment of the appropriate amount to the health care provider.
>
> 2. An administrative fine assessed by the department in an amount not to exceed $5,000 per instance of improperly disallowing or reducing payments.
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> 3. Award of the health care provider's costs, including a reasonable attorney's fee, for prosecuting the petition.

Burden of proof

47. Under the statutory scheme set out in Section 440.13(7), Florida Statutes, a health care provider can bring a reimbursement dispute to the Department by filing a petition contesting the decision of an employer/carrier to disallow or adjust payment to the health care provider for medical or other covered services provided to a workers' compensation claimant. Thus, in this case, Dr. Merayo initiated the reimbursement-dispute resolution process when he filed a petition with the Department contesting Sedgwick CMS's decision regarding reimbursement reflected in the First Notice of Disallowance. Accordingly, Dr. Merayo, as a health care provider who is asserting entitlement to reimbursement for medical services he provided to the Claimant on the dates at

issue, has the burden of proving by a preponderance of the evidence that the medical services he provided on the dates at issue do not constitute over-utilization and were medically necessary. See Department of Transp. v. J.W.C. Co., Inc., 396 So. 2d 778, 785-87; Balino v. Dep't of Health & Rehab. Servs., 348 So. 2d 349 (Fla. 1st DCA 1977); The Biscayne Inst. v. Agency for Health Care Admin., DOAH Case Nos. 03-1837, 03-1838, and 03-3890 (Recommended Order June 15, 2004), adopted in toto in AHCA Final Order 04-0420-FOF-OLC, November 1, 2004.

Nature of this Proceeding

48. As in all proceedings conducted pursuant to Section 120.57(1), Florida Statutes, the administrative proceeding is de novo. § 120.57(1)(k), Fla. Stat. Consequently "the purpose of this proceeding is to formulate final agency action, not to simply review the preliminary/proposed agency action embodied in the . . . [Department's] determination letter." CNA Ins. Cos. v. Agency for Health Care Admin., DOAH Case No. 01-4147, para. 97 (Recommended Order August 26, 2002).

49. Additionally, as in all proceedings conducted pursuant to Section 120.57(1), the parties must present evidence in the form of documents and testimony at the final hearing to support their respective positions on the issue(s) to be resolved, and this evidence forms the record upon which the findings of fact of the administrative law judge must be based. See

§ 120.57(1)(j), Fla. Stat. ("Findings of fact shall be based . . . exclusively on the evidence of record and on matters officially recognized."). Finally, as in all proceedings conducted pursuant to Section 120.57(1), Florida Statutes, the use of hearsay evidence is limited by Section 120.57(1)(c), Florida Statutes, which provides: "Hearsay evidence may be used for the purpose of supplementing or explaining other evidence, but it shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions."

Department's role in proceedings pursuant to Section 120.57(1), Florida Statutes, initiated to challenge the Department's determination in a reimbursement dispute

50. Identifying the Department's role in the instant administrative proceeding is complicated by Sedgwick CMS's failure, after proper notification, to petition to intervene as a party in this proceeding. Dr. Merayo initiated this administrative proceeding pursuant to Section 120.57(1), Florida Statutes, by filing a Petition for Administrative Hearing to challenge the November 13, 2008, Determination of the Department that he was not entitled to payment for medical services provided to the Claimant on the dates at issue, but the controversy is not one between Dr. Merayo and the Department. The real parties in interest in this matter are Dr. Merayo and Sedgwick CMS, and the dispute to be resolved in the instant proceeding is whether Dr. Merayo is entitled to reimbursement

from Sedgwick CMS. See Furtick v. William Shults Contr., 664 So. 2d 288, 290 (Fla. 1st DCA 1995)("The health care provider (or facility) and the employer/carrier are the parties with the legal interest affected by utilization review. . . . Reimbursement disputes within the scope of utilization review must thus be pursued as between the provider (or facility) and the employer/carrier in the administrative forum.")(Citation omitted.) Consequently, the Department has no legal interest in the outcome of the dispute between Dr. Merayo and Sedgwick CMS. Its role in reimbursement disputes pursuant to Section 440.13(7), Florida Statutes, is that of an adjudicator, not an advocate.

51. The Department should, therefore, have, at most, merely a nominal role in an administrative proceeding before the Division of Administrative Hearings relating to a reimbursement dispute between a health care provider and an employer/carrier. In footnote 4 of its Motion for Notice and Opportunity to Join an Indispensable Party filed January 16, 2009, the Department acknowledged that it has no interest in the outcome of a workers' compensation reimbursement dispute and is only a nominal party in reimbursement disputes because, pursuant to Section 440.13(7), Florida Statutes, it must issue a determination of whether a workers' compensation insurance carrier properly disallowed or adjusted reimbursement requests

from a health care provider. In this case, however, Sedgwick CMS chose not to intervene as a party in this proceeding. Because the Department's Determination supported Sedgwick CMS's decision to disallow payment to Dr. Merayo for the treatment provided on the dates at issue, the Department must, by default, stand in the shoes of Sedgwick CMS and defend Sedgwick CMS's decision to disallow payment to Dr. Merayo for the dates at issue as an advocate for Sedgwick CMS's decision. Cf. Specialty Risk Services v. AHCA, DOAH Case No. 01-4148, n. 10, (Recommended Order January 9, 2003)("Because the Agency is effectively a nominal party in reimbursement disputes between the provider and the employer/carrier, it should have no particular interest in the outcome of the proceeding. However, because of the provider's failure to intervene to defend her billings in this case, the Agency assumed that responsibility by default along with the resulting litigations costs that likely exceed the amounts in dispute."). The Department must, therefore, carry Sedgwick CMS's burden to produce evidence on which findings of fact in support of its decision to disallow reimbursement to Dr. Merayo can be based.[21]

52. The Department's role as advocate in this proceeding places it in a difficult position with respect to its ability to present creditable evidence to defend Sedgwick CMS's decision to disallow reimbursement to Dr. Merayo for medical services

provided on the dates at issue. The statutory scheme in Section 440.13(7), Florida Statutes, contemplates that the Department will carry out its role as the adjudicator of a reimbursement dispute by reviewing the documents provided by the health care provider and the employer/carrier. In this case, the Department reviewed the documents provided by Dr. Merayo and by Sedgwick CMS, including two independent medical examination reports completed in 1999 and three peer review reports completed in late 2007 prepared at the request of Sedgwick CMS.

53. As noted in the findings of fact above, the Department ordered an EMA Report because the physician reports included in the documentation were inconclusive regarding the proper utilization of the medical services on the dates at issue, but it expressly stated in its Determination that it relied specifically on the peer review report of Dr. Sinaikin and on the EMA Report in making the determination that Dr. Merayo was not entitled to reimbursement for medical services provided on the dates at issue herein. The Department's reliance on Dr. Sinaikin's peer review report in its role as adjudicator is entirely proper pursuant to Section 440.13(7), Florida Statutes. The Department, in its role as an advocate in the instant proceeding, cannot, however, rely on the independent medical examination and peer review reports included in the documents

submitted by Sedgwick CMS as evidence that can, of itself, support findings of fact in this Recommended Order.

54. The EMA Report prepared by Dr. Guthrie was admitted into evidence in lieu of Dr. Guthrie's live testimony, and it is the only direct evidence presented by the Department in support of Sedgwick CMS's decision to disallow payment to Dr. Merayo for medical services provided on the dates at issue. None of the physicians providing the peer review reports submitted to the Department by Sedgwick CMS testified at the final hearing, nor was their testimony offered by deposition transcript. Dr. Sinaikin's peer review report, and all of the documents provided to the Department by Sedgwick CMS, are, therefore, hearsay and cannot form the basis for findings of fact in this Recommended Order.[22]

55. The Department takes the position in its Proposed Recommended Order that all of the documents submitted by Dr. Merayo and by Sedgwick CMS are, in essence, "business records" of the Department and, therefore, may form the basis for findings of fact in this Recommended Order because they fall within the business record exception to the hearsay rule found in Section 90.803(6), Florida Statutes (2008). The Department argues in its Proposed Recommended Order that

> any and all medical records and documentation submitted to the Department by either the Petitioner or the Carrier become

> business records upon which the Department is required by law to rely upon in rendering Determination in a reimbursement dispute, pursuant to 440.13(7), Florida Statutes, and are therefore admissible as non-hearsay evidence upon which the Department and the Administrative Law Judge must base findings of fact - regardless of whether the contents of such documents constitute "out-of-court statements of fact.[23]

The Department also cites to Florida Administrative Code Rule 69L-31.011, in support of this argument, which provides in pertinent part: "The evidentiary record upon which the Department's determination will be made shall be the Petition for Resolution of Reimbursement Dispute Form and all supporting documents and records accompanying the petition and the Carrier's Response to Petition for Resolution of Reimbursement Dispute Form and all accompanying documents." The Department has, however, confused its role as advocate on Sedgwick CMS's behalf in the instant administrative proceeding under Section 120.57(1), Florida Statutes, and its role as adjudicator in reimbursement disputes under Section 440.13(7), Florida Statutes.

56. Section 90.803(6), Florida Statutes, provides, in pertinent part, that records of regularly conducted business activity are admissible as an exception to the hearsay rule, as follows:

> (a) A memorandum, report, record, or data compilation, in any form, of acts, events,

> conditions, opinion, or diagnosis, made at or near the time by, or from information transmitted by, a person with knowledge, if kept in the course of a regularly conducted business activity and if it was the regular practice of that business activity to make such memorandum, report, record, or data compilation, all as shown by the testimony of the custodian or other qualified witness, ... The term "business" as used in this paragraph includes a business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit.

57. The court in Jackson v. State, 738 So. 2d 382, 386 (Fla. 4th DCA 1999), held that "[i]n order to be admissible, a business record pursuant to section 90.803(6)(a) must be shown to have been: 1. Made at or near the time of the event; 2. By or from information transmitted by a person with knowledge; 3. Kept in the course of a regularly conducted business activity; and 4. That it was the regular practice of that business to make such a record."

58. In this case, the Department's witness testified that the Petition for Resolution of Reimbursement Dispute and supporting documents, the Carrier's Response to Petition for Resolution of Reimbursement Dispute and supporting documents, and the EMA Report are the documents upon which the Department relied in reaching its determination in the reimbursement dispute between Dr. Merayo and Sedgwick CMS. This testimony is insufficient to lay the foundation for the admission of the

documents provided the Department by Sedgwick CMS as business records of the Department.

59. The Department did not create any of the documents that were submitted to it by Sedgwick CMS; it merely compiled and reviewed these documents in its role as an adjudicator under the procedures set forth in Section 440.13(7), Florida Statutes. None of the Department's employees have personal knowledge of the facts and opinions included in the documents submitted by Sedgwick CMS, and the documents were not created by persons employed by the Department in the course of a regularly conducted activity of the Department. Consequently, even though they are in the file of this case maintained by the Department, the documents provided to the Department by Sedgwick CMS are not business records of the Department and cannot be used as the basis for findings of fact in this Recommended Order pursuant to Section 120.57(1)(c), Florida Statutes.

60. In addressing the issue of documents in the file of state agency that are offered into evidence in an administrative proceeding, Professor Charles W. Ehrhardt states:

> Records of state agencies that are admissible under Section 90.803(6) may be relied upon to supply the sole evidence upon which the administrative law judge may base a finding of fact. Frequently, an employee of the agency will appear at the hearing with the agency's complete file, which is offered as an exhibit. In a series of opinions, the First District has apparently

> determined that the files will be admissible under Section 90.803(6) if the employee's testimony demonstrates that the files are those of the state agency and that an agency employee had personal knowledge of the facts contained in each document in the file. For example, while the agency employee could testify to matters within her knowledge and her agency files, she could not lay the foundation for an affidavit from a private employer contained in the file because she would have no personal knowledge of the facts contained in the affidavit.

Charles W. Ehrhardt, Florida Evidence § 803.6c (2009 edition.)(Footnotes omitted.)

61. For these reasons, the findings of fact herein are based on the testimony of Dr. Merayo, on the EMA Report prepared by Dr. Guthrie and received in lieu of his live testimony, on the testimony of the Department's witnesses, and on the agreed facts in the parties' Joint Pre-Hearing Stipulation.[24]

Reimbursement dispute

62. Sedgwick CMS based its decision to disallow payment to Dr. Merayo for the medical services provided on the dates at issue herein on its determination that Dr. Merayo's services constituted over-utilization and that the treatment provided by Dr. Merayo on the dates at issue was excessive and not medically necessary. The following definitions, set forth in Section 440.13(1), Florida Statutes, are relevant to resolving the reimbursement dispute:

(k) "Instance of overutilization" means a specific inappropriate service or level of service provided to an injured employee that includes the provision of treatment in excess of established practice parameters and protocols of treatment established in accordance with this chapter.

(l) "Medically necessary" or "medical necessity" means any medical service or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters. The service should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature.

* * *

(o) "Pattern or practice of overutilization" means repetition of instances of overutilization within a specific medical case or multiple cases by a single health care provider.

* * *

(t) "Utilization review" means the evaluation of the appropriateness of both the level and the quality of health care and health services provided to a patient, including, but not limited to, evaluation of the appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. Such evaluation must be accomplished by means of a system that identifies the utilization of medical services based on practice parameters and protocols of treatment as provided for in this chapter.

63. Based on the findings of fact herein, Dr. Merayo has met his burden of proving by a preponderance of the evidence that the medical services he provided to the Claimant on April 11, 2007, August 21, 2007, October 16, 2007, December 11, 2007, and January 22, 2008, did not constitute over-utilization, that his treatment was not excessive, and that the services were medically necessary.[25]

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Financial Services enter a final order requiring Sedgwick CMS to remit payment to Huberto Merayo, M.D., for medical services he provided the Claimant on April 11, 2007; August 21, 2007; September 18, 2007[26]; October 16, 2007, December 11, 2007; and January 22, 2008, in accordance with the rates established in the applicable Health Care Provider Reimbursement Manual.

DONE AND ENTERED this 17th day of June, 2009, in Tallahassee, Leon County, Florida.

PATRICIA M. HART
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of June, 2009.

ENDNOTES

[1]/ Mr. DeVarona appeared on behalf of Dr. Merayo at the final hearing without having filed a notice of appearance with the Division of Administrative Hearings or, apparently, having notified the Respondent. It is noted that counsel of record in this case are Mario R. Arango and Adrienne L. Hausser, attorneys associated with Mr. DeVarona's law firm.

[2]/ All references herein to the Florida Statutes are to the 2007 edition unless otherwise indicated.

[3]/ The Department did not request reconsideration of the ruling at the final hearing receiving into evidence the documents provided by Sedgwick CMS, subject to Dr. Merayo's hearsay objection and the limitations to the use of hearsay evidence stated in Section 120.57(1)(c), Florida Statutes. It is noted that the documents comprising Respondent's Exhibit 6 were listed as an exhibit in the parties' Joint Pre-Hearing Stipulation, and no objection to the admissibility of the documents was included in that document. While the parties clearly contemplated in the Joint Pre-Hearing Stipulation that Dr. Guthrie's EMA Report would be received into evidence in lieu of his testimony and

treated as non-hearsay evidence, the parties' intent with respect to the Sedgwick CMS documents cannot be so clearly discerned from their merely being listed as an exhibit in the Joint Pre-Hearing Stipulation.

Even without an objection in the Joint Pre-Hearing Stipulation, the documents in Respondent's Exhibit 6 remain hearsay evidence and their use is limited by operation of Section 120.57(1)(c), Florida Statutes. Professor Charles W. Ehrhardt explains the effect of the statutory limitation on the use of hearsay in administrative proceedings as follows:

> Section 120.57(1)(c) specifically provides that hearsay may be used to supplement or explain other evidence, but it is not sufficient by itself to support a finding of fact unless the evidence "would be admissible over objection in civil actions." This rule, which has been rejected by most jurisdictions, has been recently referred to as "a recognized, if widely criticized, principle of review of administrative decisionmaking that goes by the name of the 'residuum rule.'" All agency findings must be supported by "competent, substantial evidence." There is disagreement as to whether unobjected to hearsay is sufficient to support a finding. Although the statute is silent on the issue, most Florida cases hold that where there is no objection to the hearsay, even when the party does not appear at the hearing, it cannot be the sole evidence to support a finding.

Charles W. Ehrhardt, Florida Evidence § 103.2 (2009 edition.)(Footnotes omitted.) Of course, the Progress Notes to which Dr. Merayo referred in his testimony and which were included in the documents provided to the Department by Sedgwick CMS are non-hearsay evidence by virtue of Dr. Merayo's testimony regarding their contents.

[4]/ Section 440.13(1)(h), Florida Statutes, defines "health care provider" in pertinent part as "a physician or any recognized practitioner who provides skilled services pursuant to a prescription or under the supervision of direction of a physician and who has been certified by the department as a

health care provider. . . ." Section 440.13(1)(c), Florida Statutes, defines "carrier" as an insurance carrier, self-insurance fund or individually self-insured employer, or assessable mutual fund."

[5]/ The facts found in this section of the Recommended Order are derived from the stipulated facts in the parties' Joint Pre-Hearing Stipulation.

[6]/ The only significant additional complaint noted in Dr. Merayo's Progress Notes was in the Progress Notes of the session held on August 21, 2007, which was a previously-scheduled monthly appointment. In addition to her usual complaints about chronic pain, the Claimant reported at this session that her father had died the night before. There is nothing further in the notes of the August 21, 2007, session to indicate that the Claimant's appearance, behavior, attitude, speech, mood, affect, perceptions, thought process, thought content, or orientation differed from her presentation during the other psychotherapy sessions at issue.

[7]/ Dr. Merayo also testified that the medication was changed on September 18, 2007, and the conflict in dates is not resolved in the record.

[8]/ Dr. Merayo added a prescription for Prevacid for the Claimant on April 11, 2007, for possible gastritis and upset stomach because the Claimant had complained at several visits of stomach pain. At some point, he ceased prescribing this medication because the Claimant was referred to a gastroenterologist for treatment of her stomach pain.

[9]/ Dr. Merayo checked the box on the Progress Notes for the December 11, 2007, session indicating that the Claimant's appearance was "unkempt and disheveled." Respondent's Exhibit 6.

[10]/ Dr. Merayo noted on April 11, 2007, that the Claimant's thought content also exhibited "preoccupations" and "worries." Respondent's Exhibit 6.

[11]/ Respondent's Exhibit 3 at page 9.

[12]/ Respondent's Exhibit 3 at page 9.

[13]/ Dr. Guthrie also discussed the intensity of the psychotherapy treatment and noted that "[t]ypically, follow-up visits after maximum medical improvement can be managed with sessions of twenty to twenty-five minutes maximum. Forty-five minute appointments suggest a pattern of over-utilization." Respondent's Exhibit 3 at page 9. There is nothing in the Sedgwick CMS letter dated April 16, 2008, First Notice of Disallowance of Claims that indicated that Sedgwick CMS considered 45-minute psychotherapy sessions to be excessive, and the Department did not address this issue in its Determination. The length of the session is not, therefore, an issue in this proceeding.

[14]/ Respondent's Exhibit 4.

[15]/ Respondent's Exhibit 4.

[16]/ Respondent's Exhibit 4.

[17]/ There is no suggestion by Dr. Merayo that Sedgwick CMS deviated from the requirements of law in issuing its First Notice of Disallowance.

[18]/ Respondent's Exhibit 5.

[19]/ It is noted that Section 440.13(8)(a), Florida Statutes, provides as follows:

> Carriers must report to the department all instances of overutilization including, but not limited to, all instances in which the carrier disallows or adjusts payment or a determination has been made that the provided or recommended treatment is in excess of the practice parameters and protocols of treatment established by this chapter. The department shall determine whether a pattern or practice of overutilization exists.

Pursuant to Section 440.13(8)(b), Florida Statutes, the Department is authorized to impose sanctions against a health care provider that it has determined engaged in a pattern or practice of over-utilization. There is nothing in the record of this proceeding to establish that the Department has made a determination of over-utilization pursuant to Section 440.13(8),

Florida Statutes; rather, the Department's Determination in this case refers only to over-utilization with respect to the reimbursement dispute between Dr. Merayo and Sedgwick CMS.

[20]/ One of the Department's witnesses testified that Dr. Merayo failed to include with his petition treatment notes for the services provided on the dates in question herein, which should have resulted in the dismissal of his petition pursuant to Section 440.13(7)(a). Nonetheless, the Department conducted its documentation review because the necessary medical records were included in the response of Sedgwick CMS. Transcript at pages 183, 179.

[21]/ It is critical that the distinction in the Department's roles as adjudicator and advocate be recognized because the Department sometimes finds itself in the position of having to defend as an advocate a determination it made as an adjudicator pursuant to Section 440.13(7), Florida Statutes, in favor of a party that chooses not to appear in the administrative proceeding conducted under Section 120.57(1), Florida Statutes.

[22]/ A review of the peer review reports leads to the conclusion that the opinions stated therein do not "supplement or explain" the opinions expressed in Dr. Guthrie's EMA Report. The EMA Report was prepared after the peer review reports so they cannot "explain" Dr. Guthrie's opinions, and the peer review reports were among the documents reviewed by Dr. Guthrie in the formulation of the opinions he stated in the EMA Report so they cannot "supplement" Dr. Guthrie's opinions.

[23]/ Respondent's Proposed Recommended Order, para. 76.

[24]/ It is noted that, in all of the workers' compensation reimbursement cases decided by the Division of Administrative Hearings, the employer/carrier has appeared as a party, either by filing a petition for an administrative hearing or by filing a petition to intervene. In these cases, the employer/carrier generally offers into evidence at least the transcript of the deposition testimony of the physicians preparing the peer review reports and the independent medical examination reports upon which the employer/carrier has based its decision to disallow reimbursement to a health care provider. The Department should not be expected to make the expenditures necessary to procure the attendance or deposition testimony of such expert witnesses in a proceeding in which it is required, by default, to defend the decision of an employer/carrier to disallow reimbursement to a health care provider. An employer/carrier that chooses not to

appear as a party in a reimbursement dispute before the Division of Administrative Hearings does so at its peril because its interests will be determined by the final order entered by the Department in such a case.

[25]/ Dr. Guthrie's opinion to the contrary is not presumed to be correct pursuant to Section 440.13(9)(c), Florida Statutes, because that statute contemplates an action before a judge of compensation claims: "The opinion of the expert medical advisor is presumed to be correct unless there is clear and convincing evidence to the contrary as determined by the judge of compensation claims."

[26]/ Even though the treatment provided by Dr. Merayo on September 18, 2007, was not an issue in this administrative proceeding, this date of service should be included in the Department's final order based on the Department's Determination that payment for treatment provided on this date did not constitute over-utilization.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this recommended order. Any exceptions to this recommended order should be filed with the agency that will issue the final order in this case.