STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

GUARANTEE INSURANCE COMPANY, Petitioner, vs. DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF WORKERS' COMPENSATION, Respondent, and LARGO MEDICAL CENTER, INC., d/b/a LARGO MEDICAL CENTER, Intervenor.	)	Case No. 09-6875

RECOMMENDED ORDER

A final hearing was conducted in this case on March 24 and 25, 2010, in Tallahassee, Florida, before Barbara J. Staros, Administrative Law Judge with the Division of Administrative Hearings.

APPEARANCES

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STATEMENT OF THE ISSUE

The issue is what is the correct amount of workers' compensation reimbursement to Largo Medical Center for emergency services rendered to patient M.C. for a work-related injury?

PRELIMINARY STATEMENT

On November 13, 2009, the Department of Financial Services, Division of Workers' Compensation (the Department) issued a Workers' Compensation Medical Services Reimbursement Dispute Determination (the Determination) pursuant to Section 440.13(7), Florida Statutes, finding that Guarantee Insurance Company (Guarantee) must reimburse Largo Medical Center (Largo) a total amount of $5,913.79 for services rendered to injured employee M.C. Guarantee and Qmedtrix Systems, Inc. (Qmedtrix) timely filed a Petition for Administrative Hearing challenging the Determination.

The Petition was transmitted to the Division of Administrative Hearings on or about December 18, 2009. Largo filed a Petition to Intervene, which was granted. A telephonic motion hearing was held on March 5, 2010. Following the hearing, the undersigned entered an Order on Pending Motions which denied the Department's Motion for Summary Recommended Order, granted Petitioners' Motion to Redact Public Information from Exhibits, and granted Petitioners' Motion to Amend. As a result, the style of the case was amended to reflect that Qmedtrix was no longer a party in this proceeding, and that Guarantee became the sole Petitioner. Largo's Unopposed Motion for Taking Official Recognition was granted.

The case proceeded to hearing as scheduled on March 24 and 25, 2010. Case numbers 09-6876 and 09-6877 were heard simultaneously with this case, but the three cases were not consolidated. Separate Recommended Orders will be entered for those related cases.

At hearing, Largo presented the testimony of Allan W. March, M.D. Largo offered Exhibits numbered 1 through 7, 24, 25, 27, and 28, which were admitted into evidence. The Department adopted Largo's case-in-chief as its own. Petitioner presented the testimony of William von Sydow and David Perlman, M.D. Petitioner's Exhibits numbered 1 through 5, 10 through 14 and 28 were admitted into evidence. Rulings were reserved on

Petitioner's Exhibits 6, 8 and 9. Upon consideration, Petitioner's Exhibits 6, 8, and 9 are rejected.[1/] Petitioner's Exhibit 7 was proffered.

A four-volume transcript was filed on April 12, 2010. The parties timely filed Proposed Recommended Orders which have been duly considered in the preparation of this Recommended Order. All references to the Florida Statutes are to 2009.

FINDINGS OF FACT

1. Petitioner, Guarantee, is a carrier within the meaning of Subsections 440.02(4) and (38), Florida Statutes, and Florida Administrative Code Rule 69L-7.602(1)(w).

2. Respondent, the Department, has exclusive jurisdiction to decide disputes relating to the reimbursement of health care providers by carriers for medical services rendered to injured workers. § 440.13(7) and (11)(c), Fla. Stat.

3. Intervenor, Largo, is a health care provider within the meaning of Subsection 440.13(1)(h), Florida Statutes. Largo is an acute care hospital located in Largo, Pinellas County, Florida.

4. On July 25, 2009, Largo provided emergency services to patient M.C., a 32-year-old female, who was injured at her place of work. M.C. was examined by Largo's emergency department physician. She received two Computed Tomography ("CT") scans without contrast dye, one of the brain and one of the cervical

spine. She also received a pregnancy test and an X-ray of her lumbar spine. The results of these diagnostic tests were negative. M.C. was given a cervical collar to wear, and was discharged.

5. Largo's total charges for M.C.'s outpatient emergency services were $7,885.05. Largo submitted its claim for reimbursement using the standard "uniform billing" form, UB-04. The UB-04 sets out each service provided to M.C., the individual charge for each service, and the total charge. The individual services on the UB-04 submitted for patient M.C. are listed as follows: urine pregnancy test; X-ray; CT scan of the cervical spine; a three-dimensional rendering of the image and its interpretation; the CT of the brain; and the emergency department visit itself.

6. Largo's claim was received by MCMC, an organization described as a "third-party administrator," and was referred in turn to Qmedtrix. Qmedtrix is a medical bill-review agent located in Portland, Oregon. Qmedtrix performs bill review by referral from carriers and third-party administrators, and performed a bill review for Guarantee of the bill submitted by Largo. For its compensation, Qmedtrix is paid a percentage of the difference, if any, between the amount billed by the facility and the amount paid by the carrier.

7. Following Qmedtrix' review, Largo received a check from Guarantee in the amount of $5,287.97, along with an "Explanation of Medical Benefits" review (EOBR), which is required to be sent along with the bill payment.

8. For reasons that are not clear, there are two EOBRs in evidence for this claim. One (Petitioner's Exhibit 4) has the logo "MCMC" in the upper left hand corner and is substantially more formal. The other (Largo's Exhibit 3) does not have any identifying logo, but the following statement appears on page two: "For questions regarding this review, please call MCMC at 1-888-350-1150." It is not clear why MCMC would have generated two different EOBRs for the same claim, but, in any event, the allowed amounts for the six components of Largo's charges and the total payment amount, $5,287.97, is the same on both EOBRs.

9. The EOBR that is Largo's Exhibit 3 sets out the six individual components of Largo's claim, and indicates that the first five were approved for reimbursement at 75 percent of the charge billed by Largo. The sixth component is the charge for the emergency department visit itself. For that charge, Largo billed $1,365.38, of which 75 per cent would be $1,024.04. The EOBR indicates the corresponding 25 percent discount from billed charges ($341.35) under a column entitled "MRA," and indicates further that an additional reduction of $625.81 was applied, leaving an approved payment of $398.22 for the emergency room

component of the claim. The additional reduction of $625.81 is under a column entitled “Ntwk Redc,” and the narrative explanation under the total payment states, ”The network discount shown above is based on your contract with the network.” Guarantee conceded at hearing that there was no contract applicable to the claim. The EOBR also has references to “convalescent care” and “PIP days,” neither of which apply to Largo’s claim.

10. The EOBR that is Guarantee’s Exhibit 4 has one column entitled “Qualify Code.” In completing an EOBR, insurers must select a code from a list of approximately 50 codes found in Florida Administrative Code Rule 69L-7.602(5)(o)2., which identifies the reason for the disallowance or adjustment. For the emergency room visit, the EOBR shows a code of 82, which is explained as follows: “Payment adjusted: Payment modified pursuant to carrier charge analysis.”

11. Both EOBRs indicate a “procedure code” of 99283. The UB-04 submitted by Largo used code 99284. These codes are among five codes that are used by hospitals to bill emergency department visits based on “level” of intensity rendered. These codes are taken from the American Medical Association’s Current Procedural Terminology (or CPT), a coding system developed for physician billing, not for hospitals. Over the years, these CPT codes have been adopted by hospitals for billing emergency

department visits. Emergency department services are billed with CPT codes 99281 through 99285.

12. After receiving the payment and EOBR, Largo timely filed a Petition for Resolution of Reimbursement Dispute, with attachments, to the Department. Largo alleged in its Petition that the correct reimbursement amount owed was $5,913.79, leaving an underpayment of $625.82.

13. Qmedtrix, acting as Guarantee's representative, then filed Guarantee's Response to Petition for Resolution of Reimbursement Dispute and attachments with the Department.

14. Attached to the Response was a letter from R.W. von Sydow dated November 5, 2009. The letter asserted that the correct payment to the hospital (Largo) should be determined on an average of usual and customary charges for all providers in a given geographic area, rather than the hospital's usual and customary charges. As authority, Mr. von Sydow cites the case of One Beacon Insurance v. Agency for Health Care Administration, 958 So. 2d 1127 (Fla. 1st DCA 2007). The letter also requested that the Department "scrutinize the bill in question in order to determine, first, whether the hospital in fact charged its usual charge for the services provided and, second, whether the billed charges are in line with the customary charges of other facilities in the community."

15. The letter further alleges that the hospital "upcoded" the emergency room visit, billing using CPT code 99284, asserting that the proper billing code should have been 99283. The letter concludes that the amount paid, $398.22, for the emergency department visit is closer to the "usual and customary" charges that Qmedtrix asserts, on behalf of Guarantee, is applicable to the claim.

16. On November 13, 2009, the Department issued its Determination. The Determination states in pertinent part:

> The Carrier Response to Petition for Resolution of Reimbursement Dispute disputes the reasonableness of the hospital's "usual and customary charges," maintains the petitioners' charges should be based on the average fee of other hospitals in the same geographic area, and references a manual not incorporated by rule. There are no rules or regulations within Florida's Workers' Compensation program prohibiting a provider from separately billing for individual revenue codes. The carrier did not dispute that the charges listed on the Form DFS-F5-DWC-90 (UB-92) or the charges listed on the itemized statement did not conform to the hospital's Charge Master. Nor did the carrier submit the hospital's Charge Master in the response or assert that the carrier performed an audit of the Charge Master to verify the accuracy of the billed charges. Therefore, since no evidence was presented to dispute the accuracy of the Form DFS-F5-DWC-90 or the itemized statement as not being representative of the Charge Master, the OMS finds that the charges billed by the hospital are the hospital's usual and customary charges.

Rule 69L-7.602, F.A.C., stipulates the appropriate EOBR codes that must be utilized when explaining to the provider the carrier's reasons for disallowance or adjustment. The EOBR submitted with the petition does not conform to the EOBR code requirements of Rule 69L-7.602(5)(q), F.A.C. Only through an EOBR is the carrier to communicate to the health care provider the carrier's reasons for disallowance or adjustment of the provider's bill.

Pursuant to s. 440.13(12), F.S., a three member panel was established to determine statewide reimbursement allowances for treatment and care of injured workers. Rule 69L-7.501, F.A.C., incorporates, by reference, the applicable reimbursement schedule created by the panel. Section 440.13(7)(c), F.S., requires the OMS to utilize this schedule in rendering its determination for this reimbursement dispute. No established authority exists to permit alternative schedules or methodologies to be utilized for hospital reimbursement other than those adopted by Rule 69L-7.501, F.A.C., unless the provider and the carrier have entered into a mutually agreeable contract.

Rule 69L-7.501, F.A.C., incorporates, by reference, the Florida Workers' Compensation Reimbursement Manual for Hospitals, 2006 Edition (Hospital Manual).

Since the carrier failed to indicate any of the services are not medically necessary, the OMS determined proper reimbursement applying the above referenced reimbursement guidelines. Therefore, the OMS has determined that the carrier improperly adjusted reimbursement to Largo Medical Center for services rendered to the above-referenced injured employee on July 25, 2009. Based upon the above analysis, the OMS has determined that correct

> reimbursement equals $5,913.79 ($7,885.05 x 75% [Hospital Manual] = $5,913.79).

17. The determination letter also informed Guarantee of its right to an administrative hearing. Guarantee timely filed a Request for Administrative Hearing, which gave rise to this proceeding.

CODING FOR M.C.'S EMERGENCY SERVICES

18. As mentioned above, Largo reported the emergency department visit using CPT Code 99284. No one from the hospital testified, but Largo's expert, Allan W. March, M.D., reviewed Largo's hospital record for M.C.

19. Dr. March is a graduate of Dartmouth College and Johns Hopkins University Medical School. He has extensive experience in, among other things, hospital physician practice and utilization review. Dr. March describes utilization as the oversight of medical care to affirm that it is appropriate, cost-effective, and medically necessary. Dr. March has worked as an emergency department physician and has personally treated upwards of 5,000 workers' compensation patients. Dr. March testified on behalf of Largo and the Department.

20. Dr. March described M.C. and her injuries from the hospital record as follows:

> This is a 32-year-old female who had just slipped at her place of work prior to arrival at the emergency department and presented in moderate distress, with

> moderate pain in the head, neck, and lower back. And the patient displayed tenderness in the posterior neck area as well as in the right lower back.

Dr. March reviewed Largo's hospital record for M.C. to analyze whether Largo appropriately used CPT code 99284, or whether it should have used a lower CPT code.

21. Largo's coding for the emergency department visit is based on the American College of Emergency Physicians' "ED Facility Level Coding Guidelines" (ACEP Guidelines). By using the ACEP Guidelines, Largo used a nationally recognized methodology in determining the level of service to which the hospital should bill. He noted that the hospital's charge sheet indicated that the level of services was marked at a Level 4. Dr. March compared the hospital's charge list with the ACEP Guidelines and found them to be essentially the same, and that the Level 4 marked on the charge sheet corresponded with CPT code 99284. Dr. March found that Largo used a nationally recognized methodology in determining the level of service to which the hospital should bill. In Dr. March's opinion, Largo correctly assigned 99284 to M.C.'s emergency department visit, and that the assignment of 99284 is substantiated by the medical record.

22. Under the ACEP guidelines, the CPT code level assigned is always the highest level at which a minimum of one "possible intervention" is found. In this case, Dr. March determined that two CT scans were ordered by the physician and performed by the hospital, which substantiates the use of a 99284 code under the ACEP Guidelines.

23. Dr. March further explained that the coding level of a hospital does not correspond directly to the coding level assigned by the physician. The physician's services are coded under the CPT-4 coding book. According to Dr. March, the CPT coding manual is applicable to facility coding only if the hospital chooses to use this manual as a basis in their methodology for coding. Further, Dr. March explained that the separate billing of the emergency department visit captures separate and distinct costs incurred by hospitals that are not included in line-items for procedures.

24. The claim submitted by Largo was sent to Qmedtrix for a bill review. Its data elements were first entered into Qmedtrix' proprietary bill-review software known as "BillChek." The software placed Largo's claim on hold for manual review. The claim was then manually reviewed by Mr. von Sydow, Director of National Dispute Resolution for Qmedtrix.

25. Although his educational background is in law, Mr. von Sydow is a certified coder certified by the American Health Information Management Association (AHIMA). Mr. von Sydow determined in his bill review that Largo should have used code 99283 instead of 99284.

26. Mr. von Sydow described what he considers to be inconsistencies between certain diagnosis codes under the International Classification of Diseases, Ninth Edition (ICD-9) and the CPT codes used to classify the emergency department visit. He considers the ICD-9 codes on Largo's claim (specifically 959.01 used to indicate "head injury, unspecified") to be inconsistent with CPT code 99284. In his view, ICD-9 corresponds more closely with CPT code 99283. Moreover, Mr. von Sydow referenced a study by the American Hospital Association (AHA) and AHIMA, which suggests that hospitals should count the number and kind of interventions to approximate the CPT factors, but that a hospital should not include in this count interventions or procedures, such as CTs or X-rays, which the hospital bills separately. He further acknowledged that the federal Centers for Medicare and Medicaid Services (CMS) allow hospitals to use their own methodology in applying the CPT codes.

27. David Perlman, M.D., received his undergraduate degree from Brown University and his medical degree from the University of Oregon. He has considerable experience as an emergency room physician. For the past six years, he has worked for Qmedtrix initially doing utilization review and as its Medical Director since 2005. Dr. Perlman testified on behalf of Guarantee.

28. Dr. Perlman is familiar with the ACEP guidelines relied upon by Dr. March and the AHA/AHIMA study relied upon by Mr. von Sydow. He is also familiar with the CPT code handbook. Dr. Perlman suggested that the use of the ACEP guidelines could result in reimbursement essentially already provided in a separate line-item. He agrees with the methodology recommended by the AMA/AHIMA study. That is, counting the number and kind of interventions or procedures to approximate the CPT book's factors to consider in selecting the code billed for emergency department services, but not including in this count interventions or procedures, such as CTs or X-rays, which the hospital bills separately.

29. In Dr. Perlman's opinion, M.C.'s injuries supported assignment of CPT code 99283 rather than 99284. The fact that M.C. underwent CT scans did not alter this conclusion. According to Dr. Perlman, use of a CT scan in a patient's emergency department treatment determines that the facility may assign a 99284 code under the ACEP guidelines. In his opinion,

this does not necessarily reflect the severity of the illness or injury.

30. Dr. Perlman acknowledged, however, that hospitals are free to use the ACEP guidelines and that many hospitals do so.

31. The preponderance of the evidence establishes that there is no national, standardized methodology for the manner in which hospitals are to apply CPT codes 99281-99285 for facility billing. The preponderance of the evidence also establishes that, while there is a difference of opinion as to whether ACEP guidelines are the best method, it is a nationally recognized method used by many hospitals. Largo's use of this methodology is supported by the weight of the evidence as appropriate. M.C.'s hospital record amply documents the interventions required for the assignment of CPT code 99284 under the ACEP guidelines. Dr. March's opinion that the separate billing of the emergency department visit captures separate and distinct costs incurred by hospitals that are not included in line-items for procedures is accepted. It is concluded that the coding of M.C.'s emergency department visit as 99284 by Largo was appropriate.

32. There is no dispute that Largo's charges as represented on the UB-04 form conform to its internal charge master, or that the services represented were in fact provided, or that they were medically necessary.

CONCLUSIONS OF LAW

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

34. This proceeding, as all other proceedings conducted under Section 120.57(1), Florida Statutes, is de novo in nature. See § 120.57(1)(k), Fla. Stat.

35. Generally, unless there is a statute which provides otherwise, the party asserting the affirmative of an issue has the burden of proof. See Department of Transportation v. J.W.C. Co., Inc., 396 So. 2d at 778, (Fla. 1st DCA 1981); Balino v. Dept. of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). It was Largo which petitioned the Department for affirmative relief and agency action, i.e., a determination that the Petitioner improperly disallowed payment. See § 440.13(7)(a). Accordingly, Largo, as the health care provider who is asserting entitlement to reimbursement for medical services provided to M.C., has the burden of proving that the charges for the services provided do not constitute over-utilization or a billing error.

36. The standard of proof is a preponderance of the evidence. See § 120.57(1)(j), Fla. Stat.

37. This case involves a reimbursement dispute under Section 440.13(7), Florida Statutes. Section 440.13, Florida Statutes, reads in pertinent part:

> (6) UTILIZATION REVIEW--Carriers shall 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 . . . 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 agency.
>
> (7) UTILIZATION AND REIMBURSEMENT DISPUTES--
>
> (a) Any health care provider . . . 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 agency results in dismissal of the petition.
>
> (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 agency 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. . . .

* * *

(11) AUDITS.--

(c) The department has exclusive jurisdiction to decide any matters concerning reimbursement, to resolve any overutilization dispute under subsection (7). . . .

* * *

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.--
(a) A three member panel is created . . . [which] shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance by physicians, hospitals,. . .

> All compensable charges for hospital outpatient care shall be at 75 percent of usual and customary charges, except as otherwise provided by this subsection.. . . (emphasis supplied)

38. Thus, subsection (6) requires carriers to review all bills for payment submitted by health care providers for errors. Subsection (7) sets forth the procedure for resolving disputes concerning payments for services rendered to injured workers.

39. Pursuant to Subsection 440.13(7)(e), Florida Statutes, the Department has adopted Florida Administrative Code Rule 69L-7.501, which incorporates by reference the Reimbursement Manual for Hospitals, 2006 Edition (the Manual), which provides in pertinent part:

> Section X: Outpatient Reimbursement
>
> A. Reimbursement Amount.
>
> Except as otherwise provided in this Section, hospital charges for services and supplies provided on an outpatient basis shall be reimbursed at seventy-five percent (75%) of usual and customary charges for medically necessary services and supplies, and shall be subject to verification and adjustment in accordance with Sections XI and XII of this Manual.[2/]

40. At issue in this proceeding is whether reimbursement to Largo should be based upon the individual hospital's usual charge or should instead be based upon the usual and customary charge of all hospitals within the same geographic area. Relying primarily on One Beacon Insurance v. Agency for Health

Care Administration, supra, Petitioner argues that reimbursement should be based upon the usual and customary charge in the community. In its Petition for Administrative Hearing, Guarantee contends that the Department "misinterpreted and misapplied Rule 69L-7.501, F.A.C. . . . [Hospital Manual] contrary to the provisions of Section 440.13(12), Fla. Stat. (2009)."

41. The Department has consistently applied the 2006 Manual to refer to the individual hospital's "usual and customary charges." (See cases officially recognized referenced in and attached to Largo's Unopposed Motion for Taking Official Recognition.)

42. Until determined otherwise in a Section 120.56, Florida Statutes, rule challenge proceeding, Florida Administrative Code Rule 69L-7.501 is presumptively valid. Any determination that a duly promulgated rule is contrary to a statute is beyond the authority of the undersigned and is within the purview of an appellate court. See Clemons v. State Risk Management Trust Fund, 870 So. 2d 881, 884 (Fla. 1st DCA 2004) (Benton, J., concurring). Accord, Amerisure Mutual Insurance Company v. Agency for Health Care Administration, DOAH Case No. 07-1755 (Order Relinquishing Jurisdiction and Closing File, January 23, 2008) (Quattlebaum, A.L.J.); FFVA Mutual v. Agency

for Health Care Administration, DOAH Case. No. 07-5414 (Order, March 26, 2008) (Wetherell, A.L.J.).

43. It is concluded that the Largo's calculation of 75 percent of its usual and customary charge is consistent with the Department's long-standing interpretation of Florida Administrative Code Rule 69L-7.501. Further, Largo established by a preponderance of the evidence that the use of code 99284 did not constitute over-utilization or a billing error.

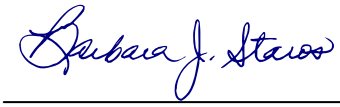
RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED:

That the Department of Financial Services, Division of Workers' Compensation, enter a Final Order requiring Petitioner to remit payment to Largo consistent with the Determination Letter dated November 13, 2009, and Section 440.13(7)(c), Florida Statutes.

DONE AND ENTERED this 17th day of June, 2010, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of June, 2010.

ENDNOTES

1/ As to Exhibits 8 and 9, Respondent/Intervenors' relevancy objections are sustained. The witness testified that he did not rely on these documents to form his opinion. Regarding Exhibit 6, Respondent/Intervenor argue that Petitioner did not comply with Section 90.956, Florida Statutes, in that the originals or duplicates of the data from which the summary is compiled was not made available; and that it is impractical and may be impossible to make available the thousands of individual hospital claims that underlie the summaries sought to be admitted. Petitioner argues that it offered to make available the "underlying data" in so far as the data is part of several sources of data for which the amount paid is based. However, what Guarantee cannot do is make available the actual data used by AHD in its summaries. Allowing access to Qmedtrix' data and providing links to other data sources does not equate to providing access to the underlying data used by AHD in compiling the summaries sought to be introduced by Guarantee. No one from AHD, the entity which compiled the data submitted by various hospitals to the federal government, testified. No one from the reporting hospitals testified. Mr. von Sydow's testimony cannot be used as a conduit for impermissible hearsay statements to be admitted as evidence. Gerber v. Iyengar, 725 So. 2d 1181 (Fla. 3rd DCA 1998). Further, this data is uncorroborated and,

therefore, is not sufficient in itself to support a finding of fact as contemplated by Section 120.57(1)(c), Florida Statutes.

Whether Mr. von Sydow can rely on these facts in forming his opinion is another matter. Petitioner argues that even if the data is inadmissible, Mr. von Sydow may rely on this data to form his opinion, citing Section 90.704, Florida Statutes. Upon review of the record, the undersigned finds that the data are of a type reasonably relied upon by experts in the subject in forming their opinions. Accordingly, Respondent/Intervenor's motion to strike Mr. von Sydow's testimony in this regard is denied.

2/ The "verification and adjustment in accordance with Sections XI and XII" of the Manual is not applicable in this case.

COPIES FURNISHED:

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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.