STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

GUARANTEE INSURANCE COMPANY, Petitioner, vs. DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF WORKERS' COMPENSATION, Respondent, and MIAMI BEACH HEALTHCARE GROUP, LTD., d/b/a AVENTURA HOSPITAL AND MEDICAL CENTER, Intervenor.	)	Case No. 09-6876

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 Aventura Medical Center for emergency services rendered to patient J.R. for a work-related injury?

PRELIMINARY STATEMENT

On November 18, 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 Aventura Hospital and Medical Center (Aventura) a total amount of $7,408.10 for services rendered to injured employee J.R.

Petitioners 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. Aventura 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 Petitioner's 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. Aventura's Unopposed Motion for taking Official Recognition was granted.

The case proceeded to hearing as scheduled on March 24 and 25, 2010. Case numbers 09-6875 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, Aventura presented the testimony of Allan W. March, M.D. Aventura offered Exhibits numbered 8 through 14, 24, 25, 27, and 28, which were admitted into evidence. The Department adopted Aventura'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, 5, 10, 15, 16, 19, 20, 21, and 28 were admitted into evidence. Rulings

were reserved on Petitioner's Exhibits 8, 9 and 18. Upon consideration, Petitioner's Exhibits 8, 9 and 18 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.

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, is charged with the review and resolution of disputes regarding the payment of providers by carriers for medical services rendered to injured workers. The Department has exclusive jurisdiction to decide reimbursement disputes. § 440.13(7) and (11)(c), Fla. Stat.

3. Intervenor, Aventura, is a health care provider within the meaning of Subsections 440.13(1)(h), Florida Statutes. Aventura is an acute care hospital located in Aventura, Miami-Dade County, Florida.

4. On May 27, 2009, Aventura provided emergency services to the patient J.R., a 41-year-old male, who was injured at his place of work. J.R. was examined by Aventura's emergency department physician. He received two Computed Tomography ("CT") scans, one of the abdomen and one of the pelvis. He also

received a urinalysis, a complete blood count (CBC), and an X-ray of his left side and ribs. J.R. was discharged after these tests.

5. Aventura's total charges for J.R.'s outpatient emergency services were $9,877.47. Aventura submitted its claim for reimbursement using the standard "uniform billing" form, UB-04. The UB-04 sets out each service provided to J.R., the individual charge for each service, and the total charge. The individual services on the UB-04 submitted for patient J.R. are listed as follows: comprehensive metabolic; assay lipase; amylase syrum; automated hemocram; urinalysis; X-ray of the ribs and chest; X-ray of the abdomen; contrast CT scan of the pelvis; contrast CT scan of the abdomen; the emergency department visit itself, and low osmolar contrast media (LOCM).

6. Aventura'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 Aventura. 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, Aventura received a check from Guarantee in the amount of $6,987.21, along with an "Explanation of Medical Benefits" review (EOBR), which is required to be sent along with the bill payment.

8. The EOBR sets out the 11 individual components of Aventura's claim, and indicates that the first nine were approved for reimbursement at 75 percent of the charge billed by Aventura. The tenth component is the charge for the emergency department visit itself. For that charge, Aventura billed $722.00, of which 75 per cent would be $541.50. The EOBR indicates the corresponding 25 percent discount from billed charges ($180.50) under a column entitled "MRA," and indicates further that an additional reduction of $143.28 was applied, leaving an approved payment of $398.22 for the emergency room component of the claim. The additional reduction of $143.28 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 eleventh and last component is the charge for the LOCM, which was completely disallowed with the explanation, "Correction to a Prior Claim." The EOBR also has references to "convalescent care" and "PIP days," neither of which apply to Aventura's claim.

9. The EOBR indicates a “procedure code” of 99283. The UB-04 submitted by Aventura also used the code 99283. This code is 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 were adopted by hospitals for billing emergency department visits. Emergency department services are billed with CPT codes 99281 through 99285.

10. After receiving the payment and EOBR, Aventura timely filed a Petition for Resolution of Reimbursement Dispute, with attachments, to the Department. Aventura alleged in its Petition that the correct reimbursement amount owed was $7,408.10, leaving an underpayment of $420.89.

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

12. Attached to the Response was a letter from Mr. von Sydow dated November 9, 2009. The letter asserted that the correct payment to the hospital (Aventura) 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."

13. The letter further alleges that the hospital "upcoded" the emergency room visit, billing using CPT code 99283, asserting that the proper billing code should have been 99282. 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.

14. On November 18, 2009, the Department issued its Determination. The Determination states in pertinent part:

> The 2006 HRM, Section 12.,A., vests specific authority in the carrier to review the hospital's Charge Master to verify charges on the itemized statement and to disallow reimbursement for specifically itemized services that do not appear to be medically necessary. No documentation submitted indicates the carrier elected to exercise this option. Moreover, the carrier did not allege that any service was deemed not "medically necessary" or that the charges present on the DWC-90 failed to match the charges on the provider's Charge Master. Therefore, the OMS finds the charges billed

> by the hospital are the hospital's usual and customary charges.
>
> The 2006 HRM provides for reimbursement of emergency room services at seventy-five percent (75%) of the hospital's usual and customary charges. Whereas, the carrier failed to substantiate is [sic] adjustments and disallowances of reimbursement on the EOBR and the hospital's billed charges are accepted as the hospital's billed charges are accepted as the hospital's usual and customary charges, the OMS determines correct total reimbursement equals $7,408.10 ($9,877.47 x 0.75).

15. 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 J.R.'S EMERGENCY SERVICES

16. As mentioned above, Aventura reported the emergency department visit using CPT Code 99283. No one from the hospital testified but Aventura's expert, Allan W. March, M.D., reviewed Aventura's hospital record for J.R.

17. 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 Intervenor and Respondent.

18. Dr. March described J.R. from the hospital record as follows:

> This is a 41-year-old male who was kicked in the flank one week prior to his presentation to the emergency department, while engaged in a fight, and was seen immediately prior to his appearance in the emergency department by a workers' compensation physician, who referred the patient to the emergency department noting a stat referral, meaning that he wanted that patient evaluated within the hour.

Dr. March reviewed Aventura's hospital record for J.R. to analyze whether Aventura appropriately used CPT code 99283.

19. Dr. March explained that Aventura's selection of CPT code 99283 for the UB-04 was, in all likelihood, due to a particular reference in J.R.'s patient record. Specifically, in that section of the record indicating "Permanent Medical Record Copy" at the bottom of each page, page 6 reflects an entry made on May 29, 2009, which was two days after the services were rendered. The May 29, 2009, entry was made by the emergency physician to assign a level for emergency physician services, and indicates "ER LEVEL III." Although the "level" reference is for physician services and not for facility services, it would have been used by Aventura's hospital coder in the absence of an emergency department charge sheet adopting the widely used

guidelines from the American College of Emergency Physicians (ACEP Guidelines)." Aventura used an alternate methodology of determining the severity level of the patient, in which the coder would have used the complexity of the medical evaluation by the physician.

20. 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. Thus, Dr. March determined that Aventura could have justified the use of CPT code 99284, which is higher than the 99283 CPT code assigned by Aventura, had the ACEP guidelines been used.

21. Dr. March further explained that the separate charge for the emergency visit is intended to compensate the hospital for "evaluation and Management" costs not captured in other line items. According to Mr. March, the separate charge does not duplicate charges for specific procedures rendered, such as a CT scan.

22. The claim submitted by Aventura 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 Aventura's claim on hold for manual review.

The claim was then manually reviewed by Mr. von Sydow, Director of National Dispute Resolution for Qmedtrix.

23. 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 Aventura should have used code 99282 instead of 99283.

24. Mr. von Sydow supported his conclusion that CPT code 99282 is the appropriate code for the emergency department visit by comparing the procedure codes and diagnosis codes reported by the hospital with examples of appropriate billing for emergency department services in the CPT code handbook. Mr. von Sydow concluded that the hospital's billing with CPT code 99283 was not appropriate and that the hospital should have billed with CPT code 99282. Mr. von Sydow also calculated that while the hospital billed $722 with CPT code 99283, its usual and customary charge for a visit billed with 99282 is $600.

25. Moreover, Mr. von Sydow referenced a study by 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.

26. 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.

27. Dr. Perlman is also familiar with the ACEP guidelines referenced 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.

28. In Dr. Perlman's opinion, J.R.'s injuries supported the assignment of CPT code 99283 as designated by Aventura. Dr. Perlman agreed with Dr. March's opinion that Aventura could have billed at a higher level (99284), but not based on the

number and kind of interventions or procedures. Dr. Perlman instead referenced examples in the ACEP guidelines.

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

30. Both Drs. March and Perlman are of the opinion that Aventura's use of CPT code 99283 was appropriate, and further agreed that Aventura could have assigned the higher code of 99284. Therefore, coding J.R.'s emergency department visit as 99283 by Aventura was appropriate.

CONCLUSIONS OF LAW

31. 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 (2009).

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

33. 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 Aventura 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, Aventura, as the health care provider which is asserting entitlement to reimbursement for medical services provided to J.R., has the burden of proving that the charges for the services provided do not constitute over-utilization.

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

35. This case involves a reimbursement dispute under Section 440.13(7), Florida Statutes (2009). 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 agency 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,. . . <u>All compensable charges for hospital outpatient care shall be at 75 percent of usual and customary charges</u>, except as otherwise provided by this subsection.. . . (emphasis supplied)

36. 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.

37. 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/]

38. At issue in this proceeding is whether reimbursement to Aventura should be based upon the individual's 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)."

39. 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 Aventura's Unopposed Motion for taking Official Recognition.)

40. 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.).

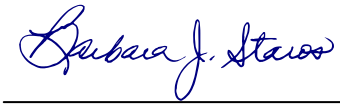
RECOMMENDATION

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 Aventura consistent with the Determination Letter dated November 18, 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 18, Respondent/Intervenor argue that Section 90.956 was not complied with in that Petitioner did not comply with the requirement of 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.